Constituting Modern Matron: Exploring Role, Identity and Action in an English NHS Trust

Liz Matykiewicz

PhD

The University of York

Management

April 2011

ABSTRACT

The English National Health Service (NHS) is a contested organisational terrain where what it means to be 'professional' is under threat from a dominant 'new managerialism' discourse. Sustained organisational change and reform during the past thirty years has impacted on the nature of professional work and role relationships between health care practitioners, managers, patients and the public. Identity is a useful analytic frame for exploring professional role dynamics and has pertinence for studies of health care professionals as they negotiate these changes.

This study considers professional identity as constructed through the enactment of a nursing role, Modern Matron, in an English NHS Trust. The role has been introduced into the nursing hierarchy in response to public and political demand for an authoritative clinical leader to take responsibility for managing standards of care within nursing; it is a hybrid management role, performed across professional and managerial boundaries, and across different organisational levels. The research has been conducted within an interpretive paradigm of social constructivism; qualitative data from semi-structured interviews is the primary source from which findings are drawn.

The findings illustrate the contradictory nature of the Modern Matron role as performed across occupational and organisational boundaries and within competing discourses of professionalism, managerialism and holistic patient-centred care. The empirical contribution of this research is to suggest that the Modern Matron role is constituted of multiple and different identities which are mediated through 'syncretic action' whereby individuals act singularly and collectively upon elements of competing discourses to create uniqueness in role and identity reflective of the specific structural, socio-political and historical circumstances in which Modern Matron is performed; this is epitomised in the collective presentation of Corporate Matron. The concept of syncretic action offers an alternative perspective through which to consider and understand the processes of identification in organisational role reconfiguration within health care; the concept has broader application to identity studies in general.

TABLE OF CONTENTS

ABSTRACT 2

TABLE OF CONTENTS 3

TABLE OF FIGURES 9

LIST OF TABLES 9

ACKNOWLEDGEMENTS 10

AUTHOR'S DECLARATION 11

1 INTRODUCTION 12

1.1 The Research Question 13

1.2 The Organisational Context 14

1.2.1 The English National Health Service (NHS) 14

1.2.2 NHS Reform 15

1.2.3 Essence of Care Benchmarking 17

1.2.4 Modern Matrons and Essence of Care 18

1.2.5 Mediating Boundaries: reconciling tensions 19

1.3 Significance of this Research 20

1.4 Contribution to Knowledge 20

1.5 Thesis Overview 21

2 IDENTITY AND RELATED CONCEPTS 24

2.1 Defining Identity and related concepts 24

2.2 Theoretical Stances 25

2.3 Identity at the level of the individual: a sense of self 27

2.4 Identity: a relational, social process 29

2.5 Developing Identity: the social self 35

2.6 A Critical Perspective on Identity 39

2.7 Discourse: a device for constructing and analyzing identity in organisations.. 44

2.8 Concluding Thoughts ... 47

3 PROFESSIONAL IDENTITY ... 49

3.1 Defining professional identity ... 49

3.2 Professionalism and Management within Public Services ... 52

3.3 Professionalism and Management in Health Care ... 54

3.3.1 Medicine and Management ... 55

3.3.2 Nursing as a Vocational Occupation ... 56

3.3.3 Nursing as a Professional Project ... 57

3.3.4 ‘Problems’ of Professionalisation ... 59

3.3.5 Reconfiguring Professional Nursing Identity ... 61

3.4 Matron: past, present and modern ... 62

3.4.1 Reform Policy: “Bring Back Matron” ... 63

3.5 Concluding Thoughts ... 68

4 METHODOLOGY ... 70

4.1 The Research Area ... 70

4.2 Doing Qualitative Research ... 72

4.3 Methodological Considerations for this Research ... 73

4.3.1 Qualitative Research in Health Care ... 73

4.3.2 Research Strategies ... 74

4.3.3 Research Methods ... 77

4.4 Analysing Qualitative Data ... 80

4.4.1 Discourse Analysis as Method ... 81

4.4.2 Understanding Grounded Theory ... 82

4.4.3 Alternative Approaches to Data Analysis ... 84

4.5 My Chosen Methodology ... 85

4.5.1 Approach and Methods ... 85

4.5.2 Data Analysis ... 86

4.5.3 Self Reflection ... 87

4.5.4 “Starting Where You Are” ... 88

4.5.5 My (un)reflective Self ... 89

4.6 Concluding Thoughts ... 90

5 CONDUCTING THE RESEARCH: THE CASE ORGANISATION ... 91

5.1 Organisational Structure ... 91

5.2 Organisational Complexity ... 95

5.3 Getting Started with PhD Research ... 97

5.3.1 Being Known to the Research Site ... 98

5.3.2 Gaining Access: Ethical Approval ... 100

5.3.3 Data Collection: Points of Contact with the Case Organisation ... 100

5.4 Transcriptions and Initial Coding ... 104

5.4.1 Initial Coding ... 105

5.5 Reframing the Research ... 106

5.6 Organising the Data ... 107

5.7 Temporality in the Research Process ... 109

5.8 Concluding Thoughts ... 110

6 MODERN MATRON: A DIFFERENTIATED ROLE ... 112

6.1 The Traditional Image of Matron: a contemporary perspective ... 113

6.1.1 Career Pathway ... 114

6.1.2 Organisational Positioning ... 115

6.1.3 Corporate Role and Responsibilities ... 116

6.1.4 Role Specification: hybrid management 118

6.2 Intra-Occupational Differences: organisational structures 120

6.2.1 Location 120

6.2.2 Rebadged or Appointed 122

6.2.3 'Part of' or 'Peripheral to' the Collective Group 125

6.3 Managing Tension between Managerial and Professional Discourse 127

6.3.1 Prioritising Clinical Care over Corporate Responsibilities 130

6.4 Essence of Care: differently interpreted; individually led 132

6.4.1 Adaptation 135

6.4.2 Leading Change 136

6.5 Concluding Thoughts 138

7 MODERN MATRON: AN AUTHORITATIVE ACT? 140

7.1 Clinical Leadership: working with subordinates 140

7.1.1 'All and Everything': contradiction in role 144

7.2 Working with other occupations: a different type of authority 146

7.2.1 Working with Medical Colleagues 146

7.2.2 Working with Contractors 149

7.3 Visibility: interacting with patients 150

7.4 Concluding Thoughts 153

8 MODERN MATRON: A COHESIVE ROLE 155

8.1 Congruence through Corporate Collectivity 155

8.1.1 The Professional Group: the Modern Matron Forum 157

8.1.2 A Corporate Identity 160

8.1.3 Shared Ideological Values 161

8.1.4 Reinstating Fundamental Values of Care 165

8.2 Performing Corporate Matron: implementation of Essence of Care 166
8.2.1 Implementing Essence of Care across the Trust 167
8.2.2 Validating Corporate Matron 170
8.3 Concluding Thoughts... 173
9 CONCLUDING DISCUSSION: Constituting Modern Matron through syncretic action 175
9.1 Findings Synopsis 176
9.1.1 Modern Matron through an Individual Lens: differentiation 177
9.1.2 Modern Matron: discursive performance 178
9.1.3 Modern Matron through a Collectivity Lens: cohesiveness.................... 179
9.1.4 Modern Matron through an ideological lens: competing discourses 179
9.2 Constituting Modern Matron: structure and agency 180
9.2.1 Essence of Care: a mediating text 181
9.2.2 Working within a 'Culture of Performativity' 183
9.2.3 Syncretism 186
9.2.4 Implementing Essence of Care: syncretic action 189
9.3 Further Considerations for this Research 191
Appendix A: Conference Paper Abstract 192
Appendix B: Example of Methodological Choices 193
Appendix C: Methodological Choices in Health Care Literature 194
Appendix D: Journal Article Abstract 196
Appendix E: Letter of Invitation 197
Appendix F: Participant Information Sheet 198
Appendix G: Consent Form 200
Appendix H: Interview Topic Outline 201

Appendix I: Example Transcript 202

Appendix J: Initial Coding: descriptive hierarchy 222

Appendix K: Data Extract - example of Initial Coding.. 223

Appendix L: Focused coding matrix 226

Appendix M: Search Results “Syncretism” 227

LIST OF ABBREVIATIONS 228

REFERENCES 229

BIBLIOGRAPHY 252

TABLE OF FIGURES

Figure 3.1: Matron's 10 Key Responsibilities 64

Figure 5.1: Respondent Career Pathways 92

Figure 5.2: Generic Organisational Structure 93

Figure 5.3: Organisational Structure (Dermatology) 94

Figure 5.4: Organisational Structure (Surgical Services & Cardiothoracic Services) 95

Figure 5.5: Matron Areas of Responsibility 96

Figure 5.6: Data Analysis Matrix 107

Figure 5.7: Three Dimensional Analytical Framework 108

Figure 6.1: Hattie Jacques as "Matron" 113

Figure 7.1: A Matron in Lilac 152

Figure 8.1: Implementation Structure for Essence of Care 169

Figure 9.1: Inter-relational Framework 177

Figure 9.2: Inter-relational Framework with Essence of Care 181

LIST OF TABLES

Table 6.1: Variation in Matron Role Specification 118

Table 6.2: First or Second Wave Recruitment to Post 123

Table 6.3: Respondents' Involvement with Essence of Care 133

ACKNOWLEDGEMENTS

First and foremost, I give my sincere thanks to the dedicated Modern Matrons who enthusiastically gave their time and shared their experiences without which this research would not have been possible.

I would like to offer my heartfelt thanks to my supervisory team, Lynne Baxter and Robert McMurray, for your constant encouragement, wisdom and guidance through the undulating course of my doctoral studies.

My gratitude also to colleagues at Newcastle Business School for their help and encouragement during the first steps towards this PhD, and to The York Management School for enabling me to complete the journey.

To Dave Ashton, thank you for giving your time and reflections on this work as it has progressed.

And finally, to Anton, Zack, Luke, my parents and parents-in-law, family and friends, for your patience, understanding and unfailing support, thank you, with love.

AUTHOR'S DECLARATION

In June 2010, I presented aspects of this research at the Gender, Work and Organisation Conference, Keele University, UK. The paper reflected work in progress, and offered an opportunity to explore my research data in relation to concepts of gender, identity and discourse (Appendix A).

1 INTRODUCTION

Identity is a useful frame by which to study organisation and, in particular, to explore professional role dynamics (Alvesson et al., 2008); this has pertinence to studies in health care given the changing context of work, roles and relationships between professionals and managers; professionals and their patients and between professionals themselves. Contemporary issues of new professionalism, role transition and reconfiguration emerge as health professionals engage with an increasingly managerialist agenda and act to reconcile tensions between managerial and professional discourses, rhetoric and ideologies. Currie et al. (2010) argue that most role transition studies occur at the level of institutional analysis identifying a gap in the research literature to consider micro level analysis surmising that "micro level studies are important because they ground assertions about renegotiation of boundaries between health care professionals in the face of policy change" (ibid. p.955).

This is a study of identity as socially constructed and dynamic, constituted through inter-relations of: self and other; the subjective and objective; agency and structure; action and word. These dualisms create similarity and difference through which identity emerges. Identity is not fixed rather it is relational and situated; fluid, transient and ever-changing. An individual holds multiple identities, contingent on time and place; past and present. Identity is a useful analytic lens in organisational research (Alvesson et al., 2008) offering insight into social processes which constitute individuals, groups and organisations; these processes are shaped and communicated through language as written text and spoken word. Language brings meaning and significance to identity formation hence identity becomes a discursive performance (Ainsworth & Hardy, 2004; Goffman, 1990; Sluss & Ashforth, 2007).

Professional identity has traditionally formed on the basis of specialist knowledge and expertise which confer power, authority and social status upon the professional individual and group (Freidson, 2001; Hughes, 1963). Within public sector organisations, and health care in particular, professionalism has been challenged by the philosophy of New Public Management (NPM). Managerialism seeks to reconfigure the specialized monopoly of knowledge, authoritative control and autonomous practice of professionals through principles of external control and regulation, and democratization

of the relationships between professional, manager and layperson (Dent & Whitehead, 2002). Public organisations have become a contested terrain of competing discourses of managerialism and professionalism; in response there has been a reconfiguration of role resulting in the emergence of the hybrid professional-manager, an individual who works across professional and managerial boundaries (Ainsworth et al., 2009; Causer & Exworthy, 1999).

This study considers professional identity as constructed through the enactment of a new and politically contested nursing role, Modern Matron, in an English National Health Service (NHS) Trust; a role which exemplifies the hybrid professional-manager. The research is positioned against a backdrop of complex national policy implementation both in role and work practices within an organisational setting characterized by change, fluidity and uncertainty. This research presents an exploration of identity construction as individuals manage ambiguity, tension and contradiction in their role performance at the micro level of organisation, thus addressing the gap in current literature on role transition (Currie et al., 2010).

1.1 The Research Question

Within the literature, the hybridised role is problematised as an ideological conflict, a struggle for the professional working within the new hegemonic managerialist order (Dent & Whitehead, 2002) prompting the research question as to how professionals negotiate and mediate their roles within such ideological and organisational tumult. The research draws from identity theory, in particular, relational identity (Sluss & Ashforth, 2007) and collective action (Cerulo, 1997) encompassing social and psychological interaction, reflected in practice and performance (Pullen, 2006).

Some theoretical issues addressed in this research are: how individuals reconcile differences between managerial and professional ideologies as they perform in the Modern Matron role; how individuals negotiate working across occupational boundaries and how individuals singularly and collectively organise and control work across organisational boundaries. This is a senior nurse position with responsibility for implementing national and corporate policies to reform practice, working across and

within organisational and professional boundaries. Of interest is how the Modern Matrons perceive their role and responsibilities; how they talk about what they do, how they respond to policy imperatives and how they interpret and act upon policy. Therefore, using the example of Modern Matron in an English NHS Trust, the following research questions are explored:

- **How is identity performed?**
- **What is/are the Modern Matron Role configuration(s)?**
- **How do individuals interrelate with self and other in role performance?**
- **How do individuals make sense of and act upon role responsibilities?**

1.2 The Organisational Context

For a greater understanding of the construction and identification of Modern Matron as a senior nursing professional in the contemporary NHS, it is necessary to take a moment to review the organisational context, governed by a discourse of reform, within which the role is situated.

1.2.1 The English National Health Service (NHS)

At the time of writing, the English NHS is the largest employer in Europe, with over 1 million staff providing health care services to a population of 57 million (NHS Website (a), accessed 06-04-11). Structurally, health care services are divided between primary and secondary care provision. Primary care is delivered in the community, through contracts with General Practitioners (GPs), Dentists, Optometrists, Pharmacists and other health related services. Primary Care Trusts manage all primary care provision and play a major part in commissioning services from secondary care, controlling 80% of the NHS budget (NHS website (b), accessed 13-03-11). Acute Trusts are responsible for the delivery of secondary care; hospital based acute services, through both emergency and elective care. Some Acute Trusts also deliver tertiary specialist care regionally and nationally. Strategic Health Authorities are regional organisations which oversee and manage local health care provision. They provide a link between the Department of Health and local health care organisations.

1.2.2 NHS Reform

An historical review of the NHS charts a series of reforms to the structure of the organisation since its inception in 1948. In particular, during the past 30 years there has been increasing number of reforms by successive governments which have aimed to improve the efficiency, quality and effectiveness of health service provision (Ham, 2009). These reforms are grounded in the philosophy of New Public Management (NPM) defined by Hood, in his seminal article (1991, p.5), as "a marriage of two different streams of ideas" between post war New Institutional Economics and "successive waves of business type managerialism." The core values of NPM focus upon ensuring efficiency and cost effectiveness; putting the customer at the centre of service design and delivery; ensuring honesty and fairness through effective accountability and governance systems; using regulation and performance management for improved control; ensuring long-term resilience through risk management and engendering a learning culture (Hood, 1991).

Since 1993, top down government reform policies to reorganise the NHS has intensified, with rapid, frequent change and major structural reforms occurring on average, "one every two years" (Walshe, 2010, p.160); the intensity, pace and volume of reform has been criticised for i) excessive costs, particularly pertinent in a time of public spending austerity; ii) the negative impact it has had on service delivery as constant reform detracts from the fundamental job of caring for people; and iii) concern that organisational reform and restructuring does not achieve the improvements it aims for, rather it destabilises the health care system (Walshe, 2010). In spite of such criticisms, reform continues; for example, at the time of writing there is a new proposal to reform the current organisational structure of the NHS to give General Practitioners control of the NHS budget (BBC News, 5/4/11) and abolish the existing commissioning bodies, Primary Care Trusts and Strategic Health Authorities.

The two reform policies which are the focus of this research, Modern Matrons and Essence of Care benchmarking, were introduced during the period 2000-2005, a time of intense government led reform activity which aimed at improving the quality of health care provision in the English NHS. This aim translated into a series of policy initiatives: *The NHS Plan* (DH, 2000) sets out a clear vision for a patient centred, quality led NHS

with proposals to change the ways in which health services could be funded, led and delivered. Outcome based performance management and customer-oriented service design and delivery permeates NHS reform policy (Hannigan, 1998). For example, *A First Class Service* (DH, 1998) sets out a strategy for quality improvement, introducing the performance assessment framework for setting, delivering and monitoring standards. *Making a Difference* (DH, 1999a) presented a strategy for nursing, midwifery and health visiting, putting clinical governance at the heart of quality improvement within these occupational fields. Clinical Governance (DH, 1999b) is the performance framework by which to improve and assure the quality of clinical services for patients and through which medical and clinical accountability is managed (Ham, 2009).

The Modern Matron role has been introduced into the English NHS nursing hierarchy in response to political and public demands for a visible authority to take accountability for standards of clinical practice (managerial role) and to provide strong clinical leadership and support to other nursing staff (professional role); it is a hybrid management role emerging from a political discourse of health care reform and specified through top-down government policy (Bolton, 2003; Forbes & Hallier, 2006; Savage & Scott, 2004).

The policy initiative to "bring back" the Modern Matron role emerged from the *NHS Plan* (DH, 2000) with policy guidance making explicit the Modern Matrons' accountability for clinical governance, and within this, Essence of Care. The policy documentation, in line with organisational change literature (Kotter, 1995) emphasises strong and supportive leadership as essential to successful implementation and it is in this respect that it links most strongly to the newly constructed role of the Modern Matron.

It is the relationship between role (Modern Matron) and policy implementation (Essence of Care) that emerges as the focal point for my research; identity is relational and constructed through social interaction with others and with the environment in which the individual lives and works. The Modern Matron takes a leading role in implementing policy initiatives which in turn, contribute in defining and constituting the role; a dynamic interplay of subject and object (Berger and Luckmann, 1991). In order to understand the relevance of Essence of Care benchmarking to the process of identity construction of Modern Matron, the policy initiative needs to be explained.

1.2.3 Essence of Care Benchmarking

The reform agenda to deliver high quality, patient focused care has led to a performance oriented culture within the NHS (Adcroft & Willis, 2005; Davies & Lampel, 1998; Ferlie et al., 1996), focusing on outcomes, measured by a range of targets, ranking and information-gathering systems, including benchmarking (Hood, 2007; Smith, 2005). Benchmarking can be defined as "the search for and implementation of best practice through comparison and learning from those who demonstrate better quality performance within a continuous improvement cycle of assessment, action and review" (Matykiewicz & Ashton, 2005, p.469). Clinical benchmarking, a process of measuring, comparing and learning from practice has gained prominence as a way by which to develop an evidence based approach to service improvement (Bullivant, 1996; Ellis, 2000; Enderby, 2003). Some of the fundamental aspects of the Essence of Care clinical benchmarking process such as development of best practice standards; use of reflective learning cycles; and recognition of the need for supportive leadership have been influenced by industrial benchmarking (Camp, 1989; Ellis, 2004; Watson, 1993; Zairi, 1992), illustrative of the managerialist endeavour to bring private management practices into public services (Flynn, 2007).

Essence of Care has been designed as a structured approach to sharing and comparing practice in health and social care settings, with a view to improving the quality of care delivery (Ellis et al., 2000a; 2000b) and is an attempt to support policy objectives to improve quality (DH, 1998; 1999a) by putting the patient first and to ensure health practitioners "get the basics of care" right (DH, 2000). Ultimately, Essence of Care benchmarking is claimed to be "the bedrock of clinical governance" (Badham et al., 2006, p.23).

Essence of Care embodies two prevalent discourses in contemporary nursing; managerialism and holistic care. It is a managerialist device which externally monitors and audits professional practice in delivering care (Hewison, 1999). The policy documentation is steeped in managerialist discourse whereby objective performance measurement through monitoring and audit is assumed to assure better standards of care than reliance on professional knowledge and judgement (Dent & Whitehead, 2002), symbolic of the neo-liberal rhetoric within new public management which threatens to

undermine professional knowledge and practice (Freidson, 2001). Both by title and content, it aligns with core values of nursing (White, 2002) through a discourse of fundamental principles care, the foundation of 'hands on' nursing practice (Taylor, 1997).

This presents as paradoxical, on the one hand, a managerialist approach to controlling nursing practice and yet, appealing to the professional sensitivities of what nursing practice should be. This paradox is reflected back through the Modern Matron role with the remit to monitor and control standards of nursing care whilst also being true to vocational nursing roots. How then do the Modern Matrons mediate these apparent tensions?

1.2.4 Modern Matrons and Essence of Care

Essence of Care has been centrally devised but with significant input from consultations with patients and service users; it offers guidance rather than prescription on how it should be implemented which gives the Modern Matrons license over how they interpret the initiative at the micro organisational level; it is this process of interpretation that has significance for my research.

Traditional policy implementation literature shows that it can either be a top-down approach, centrally driven, by statute (Mazmanian & Sabatier, 1989) or bottom-up, devised centrally at the institutional macro-level with significant ambiguity and flexibility for implementation at the local, micro-level. Bottom-up implementation is highly contextualized, often resulting in national policy being devised in consideration of the end user and service deliverer and necessarily flexible in how it is interpreted and implemented locally (Berman, 1978) which has resonance with the way in which Essence of Care has been developed by the Modern Matrons in this case organisation. Matland (1995, p.165) refers to experimental implementation where "contextual conditions dominate the process" as high ambiguity in the policy allows for flexibility in interpretation at local level giving space for experimentation and iteration in the implementation process.

1.2.5 Mediating Boundaries: reconciling tensions

There is growing evidence within the literature that professionals engage in a "re-writing" of managerial discourse (Dent & Barry, 2004) in order to maintain control and autonomy in practice and that this leads to a reconfiguring of role and identity. Hotho (2008, p.721) argues that "individual professionals use and rewrite scripts of their profession but also draw upon new scripts as they engage with local change and to that extent, they contribute from the local level upwards to the changing identity of their profession." This is similar to Whitchurch (2008) who categorises professionals as "bounded", "cross-boundary" or "unbounded" according to the extent to which an individual "might interpret and adapt a role, as opposed to performing it precisely in accordance with pre-determined guidelines" (ibid. p.376). Meanwhile, Bolton (2003, p.129) writes that "the influence of nurses' attachment to their professional role becomes clear in the way that they reinterpret senior managers directives, manipulating and moulding policy initiatives into their own frame of reference."

Lozeau et al. (2002) explore this concept of congruence with basic underlying assumptions in their research on the implementation of private sector managerial techniques (quality management and strategic planning) into public sector organisations, specifically public health hospitals. Their question is the extent to which managerialist initiatives are "corrupted" when implemented at the micro level of, in this case, a professionalised organisation. They argue that a "social re-construction" process occurs as actors involved in the implementation process at a micro level reconcile their professional ideology with the managerial techniques being performed.

In this climate of new professionalism, Hewison (1999) discusses the influence that nurses can have at the micro level of implementation, proposing that at the point at which the nurse interacts with a managerialist device (policy or technique), the opportunity arises for that device to be interpreted and 'corrupted' to fit with the nurse's preferred ideology, and in doing so, reconstitute the 'professional' role identity, and power relations within it. Pope et al. (2006) discuss similar findings from their research of the implementation of an organisational change programme and the different interpretations and meanings ascribed by individuals across the macro, meso and micro levels of the organisation. Hewison (1999) suggests that policy is a vehicle through

which individuals and groups can promote their ideological values; a “mediating text” between macro and micro levels of organisation (Liaschenko & Peter, 2004).

Whilst there are nuances between the various citations above, they all suggest that an individual will try to make sense of their role or the task they are performing in accordance with their individually held ‘mental map’ (Weick, 1995) or tacitly held assumptions and beliefs; an internal framework against which external influences and stimuli are assimilated.

These are interesting ideas to explore in relation to the constitution of the Modern Matron role as it suggests that how the professional nurse (Modern Matron) reacts to, interacts with, and acts upon the managerialist device of Essence of Care may be indicative of the deep-seated person based beliefs and values held at the level of self (Brewer, 2001), which then influence their social identity construction.

1.3 Significance of this Research

This research is positioned within the context of health care management and more broadly, public management. It addresses a gap in the literature offering empirical data on identity construction and role formation at the micro level of individual within organisation (Currie et al., 2010). The findings have implications for: theory, in relation to how role and identity is formed from a combination of historical, cultural and socio-political constructs; and for policy in terms of role and identity as contingent constructs within a dynamic, ever-changing organisational environment.

1.4 Contribution to Knowledge

My contribution to the field of knowledge is to suggest an alternative perspective by which to consider and understand the processes of identification in organisational role reconfiguration within health care; **syncretic action** brings divergent elements together through the vehicle of policy implementation to discursively mediate role and identity; the concept has broader application to identity studies in general.

This study shows that Modern Matron is a role replete with contradiction presented as "new" in contemporary nursing and yet a reincarnation of Matron, a senior nurse role in the hospital hierarchy fifty years ago; a position reflecting the professionalisation of nursing management but with a remit to focus on the essence of vocational care in nursing practice; a figure of authority within nursing but a figurehead when working across occupational boundaries. Modern Matron performs on different organisational stages and mediates between different occupational groups; it is through these inter-relations, within and between different discourses of managerialism, professionalism and nursing care that Modern Matron identity emerges.

The findings suggest that rather than being subsumed within a managerialist discourse as current literature suggests, Modern Matron is discursively constituted from multiple, disparate and divergent influences. I argue that role and identity configuration occur through a process of syncretic action, where individuals singularly and collectively draw from elements of competing discourses, reflective of structural, socio-political and historical circumstances and specific to time and place. Multiple situated identities reflective of self, individual and collective action emerge, epitomised by the collective presentation of Corporate Matron.

Whilst syncretism broadly refers to the process of blending disparate elements together (Stewart, 1999), I conceptualise syncretic action to describe how individuals draw from different ideological scripts, perform at different organisational levels and negotiate power in relation to others. I argue that policy, in this case the Essence of Care benchmarking initiative, acts as a mediating text by which individuals make sense of the contested organisational terrain and take action to constitute themselves in the role, drawing from discursive, situational identities.

1.5 Thesis Overview

This thesis begins with a review of the literature on identity and related concepts (Chapter Two); here consideration is given to literature from across disciplines such as psychology, sociology and organisation theory and presents the various epistemological stances on identity that exist. In this chapter, identity is argued to be socially constructed

and discursively performed (Alvesson et al., 2008; Berger & Luckmann, 1991; Foucault, 1971; 1982; Sveningsson & Alvesson, 2003). The chapter presents some key concepts which can be applied to the research data; identity as performed on different stages (Goffman, 1990); identity as relational, formed through role-relationships between Individual and Other (Ashforth & Mael, 1989; Brewer, 2001; Sluss & Ashforth, 2007) and identity as emerging from collective action (Cerulo, 1997).

Chapter Three continues the review of the literature on professional identity. Having defined professional identity, the focus moves onto professionalism and management in health care. Here, a distinction is made between medical and nursing occupations within health care and attention given to understanding the relevance of professional identity to nursing. This leads onto a discussion of NHS reform and policy relating to the introduction of Modern Matron into the English NHS, outlining the problem of the hybrid professional-manager role in the contested terrain of health care management.

Chapter Four presents the methodology for this research; approaches and methods for qualitative research are considered followed by a discussion on analysis techniques for qualitative data. The choice to approach this as case study research, using primary method of semi-structured interviews with observation and document analysis is presented. Thematic coding, influenced by principles of Grounded Theory, is chosen as appropriate for data analysis; the findings are presented using a heuristic framework which considers the data through individual, collective and ideological lenses (Exworthy & Halford, 1999). Reflexivity is integral to qualitative research as the subjectivities of the researcher are entwined in the research process and interpretation of data. Chapter Five takes a reflective stance as I write myself in to the research introducing my involvement with the case organisation before and during the research. Through this, I highlight the inductive nature of the research process, as initial findings from the data led to a reframing of the research towards Modern Matron as a situated identity project.

The following three chapters present a discussion of findings around three themes: Chapter Six considers the Modern Matron through the lens of individual, illustrating the varied and diverse nature of the role which creates differentiated identity when performed in different spaces at the micro level of organisation; Chapter Seven considers the discursive nature of identification through inter and intra occupational role

relationships as issues of power, authority and autonomy are negotiated in dynamic relational processes; Chapter Eight presents the Modern Matron as a collective endeavour, presenting a cohesive and unified identity, performed on a corporate stage. The discussion of findings reveals multiple identities of Modern Matron as the role is performed within and between organisational spaces and occupational boundaries. These identities reflect the contradictions and tensions inherent to the role as a hybrid professional-manager.

Chapter Nine offers a concluding discussion stating the empirical contribution of this research, presenting the argument that the role contradictions outlined in the findings are negotiated and mediated through implementation of the policy, Essence of Care. I argue this is a process of syncretic action as policy acts as a 'mediating text' through which the individual can interpret and make sense of self, role and identity. The concept of syncretic action, the contribution from this research, is discussed in relation to relevant theory, in particular the notion of performativity in public management literature (Dent & Whitehead, 2002). This chapter concludes with considerations for further research.

2 IDENTITY AND RELATED CONCEPTS

This chapter explores identity and related concepts with a view to establishing its relevance to the Modern Matron as an organisation, occupation and personal construct, essentially a study of self, identity and the social construction of a shared reality (Berger & Luckmann, 1991; Goffman, 1990; Holstein & Gubrium, 2000). The chapter considers issues of definition, theoretical stances and devices through which identity and related concepts are constructed and communicated. It concludes with an evaluation of the literature in relation to the present research.

2.1 Defining Identity and related concepts

When searching for a definition of ‘identity’ you can expect to find descriptions referring to ideas such as sameness, oneness and individuality. Identity comprises characteristics by which an individual can be recognised and identified. Within any discussion of identity, there is also an acknowledgement of self, the ‘distinct individuality or identity of a person or thing’ (Collins English Dictionary, 2000, p.1395). Self and identity are inextricably linked (Mead, 1934 cited in Holstein and Gubrium, 2000) within the literature although the nature of this relationship is a matter for debate, Callero (2003, p.119) specifies the distinction as “self…a defining feature of human nature and is thus both trans-historical and universal, a quality that does not extend to identities, which are taken to be the social products of the self process.” Meanwhile, Alvesson et al. (2008, p.6) point out that “identity studies often reflect a range of tacit and explicit positions on this matter, for example, depicting identity as hierarchically integrated into dominant notions of self or, conversely, as fragmented into manifold, simultaneous and shifting notions of self.”

The issue is epistemological, dependent upon whether self and identity are regarded as fixed and bounded entities or dynamic concepts, constantly shifting and shaping within the social world; identity as something that has become or as a process of becoming (Pullen, 2006). A simpler distinction may be that whilst self pertains to the individual, identity can be multiple and varied, relating to one and many. This dichotomy of individual and collective is a consistent theme within the identity literature, along with

issues such as reflexivity, agency and relational interactions as will be discussed below. Before considering the features and elements comprising identity, it is necessary to understand the various theoretical stances put forward in the literature.

2.2 Theoretical Stances

Brewer (2001) provides a useful overview of the origins and taxonomy of identity, believing it to be a widely used term across many disciplines, from different theoretical perspectives but without a common definition. Horton (2006, p.534) describes how "much of the traditional literature on identity emanates from sociology and anthropology…but more recently from organisational psychology and organisational theory." Sveningsson and Alvesson (2003, p.1163) summarise identity as "one of the most popular topics in contemporary organisation studies, as in many other branches of the social sciences."

The theoretical perspectives underpinning identity literature tend to be presented as a movement through traditional functional to contemporary critical epistemologies (Brewer, 2001; Hotho, 2008; Leidner, 2006; Macdonald, 2006; Sveningsson & Alvesson, 2003). Alvesson et al. (2008) in their review of identity scholarship in organisation studies refer to different "metatheoretical orientations" (ibid. p.8) characterised across the literature, namely functionalist, interpretivist and critical/emancipatory. They suggest that the functionalist perspective tends to focus on the technical, cognitive aspects of identity as "an intervening variable" (ibid. p.8), which can be controlled to facilitate a desired outcome in a specific social context.

The implication is that, when taking a functionalist stance, self and identity are constructed according to distinct, stereotypical perceptions of expected behaviour within a defined social context hence bounded and static. This is prevalent in much of the traditional psychological literature on self and identity as illustrated by Burrell's (2006, p.162) comment, "there had long been a willingness to see identity as a thing fixed and stable in the minds of those who analysed it: a modernist concept, that the self was

somehow primeval, a determinant of behaviour, and historically rooted in the deep past, that does not sit well with its contingent treatment today."

In contrast, an interpretivist orientation "seeks enhanced understanding of human cultural experiences, or how we communicate to generate and transform meaning" (Alvesson et al., 2008, p.8) focusing on the complex inter-relationships between self and others. The interpretivist perspective, characterised by interactionist and constructivist approaches, emerged as an alternative theoretical standpoint to the highly structured and 'static' functionalist stance (Sveningsson & Alvesson, 2003) with the premise that meaning and identity are derived through social interactions between individuals and groups. Meaning has a central role in the process of organising human behaviour, and is generated through symbols and shared realities (Knights & Wilmott, 1999). Drawing from the work of Emile Durkheim on ritual and symbols, key theorists have used ethnography to explore "individual and collective struggles for status, dignity, and autonomy" centring on "the management of self presentation and of relations with others, on meanings of work and on symbols of membership and status" (Leidner, 2006, p.429). Much of the sociological literature on self and identity falls within this interpretivist paradigm (Brown, 2001).

Critics of both functionalism and interpretivism argue against a concept of an identifiable unitary self, suggesting instead that attention should be given to the process of "becoming identified" in which there can be multiple and conflicting selves which are contextual, emergent and contradictory. This perspective, critical and emancipatory in orientation (Alvesson et al., 2008), moves towards discursive and constructed approaches to identification, positioning identity as central to issues on meaning, motivation, commitment, loyalty, change, resistance, power, authority and conflict (Sveningsson & Alvesson, 2003).

Identity is an established analytical frame through which one can understand "a range of organisational settings and phenomena while bridging the levels from micro to macro" (Alvesson et al., 2008, p.7). Alvesson et al. (2008) found that contemporary organisation studies on identity tend towards interpretivist or critical perspectives, which hold "a vital

key to understanding the complex, unfolding and dynamic relationship between self, work and organisation" (ibid. p.8-9). They suggest that there is considerable scope in linking the meta-theoretical perspectives for a more coherent understanding of identity, a point also made by Brown (2001, p.113) who outlines "some interesting and potentially fruitful lines of inquiry relating to identity in organisations…that current levels of interest from diverse communities of social science scholars, may indicate that it has more scope for linking and cohering different social scientific research agendas than has so far been recognised." To understand the provenance of identity, its establishment as a theoretical construct in organisation studies and future directions of identity scholarship, a closer analysis of the literature is required.

2.3 Identity at the level of the individual: a sense of self

If we agree that self and identity pertain to the individual, as implied in the definitions given above, then it makes sense to explore what individual and individualism mean. Collin (1996) highlights how the concept of the individual, as a separate, autonomous and bounded entity, independent from society, is central to western thinking. Holstein and Gubrium (2000) also refer to the specific understanding of individuality in western thought, illustrating how other non western societies do not necessarily conceive of a subjective self, separate from others. This taken-for-granted notion of the individual as central and sovereign is essential to the functionalist approach to self and identity studies and "largely enshrined in psychology" (Collin, 1996, p.9).

Baumeister (1987) presents a review of the history of selfhood from medieval times to the 20th century from psychological perspective, asserting like Giddens (1991) that selfhood is a modern phenomenon, emerging alongside the rise of individualism, liberalism and secularisation within western society. Functionalist thought holds that the individual derives from nature, and individual characteristics can be causally explained or are the result of innate dispositions. As an object, distinct from others, the individual could be organised and controlled through mechanisms in society such as work, time and space, thus fitting with the prevailing ideology of industrialisation and modernity of

the time (Collin, 1996). Baumeister (1987) argues that over time, as self has become more individualised, it has become more problematic.

Whereas in medieval times an individual was assigned a position in society according to lineage and gender, in modern society, an individual can be defined not only through lineage and gender but also through achievement of a particular position or role (e.g. wealth, status, motherhood, knighthood) and choice (e.g. religious/political affiliation, spouse, career) and these processes of self-definition are complex and continually changing. Baumeister suggests that the "problem of self" culminates in the relation between the individual (private self) and society (public self) stating "the problematic nature of the individual's relation to society stemmed from being inextricably bound up in an interpersonal society but needing to define one's own meaning and purpose in life actively, because society no longer provides the individual with these" (ibid. p.174), thus illustrating the traditional approach to considering self as first and foremost, an individual trait (Baumeister, 1987; Brown, 2001; Callero, 1991; Cerulo, 1997; Collin, 1996; Howard, 1991).

It is an introspective consideration of how the individual conceives, knows and defines self and identity, analysing these issues through lenses of cognition and behaviourism. Banaji and Prentice (1994) similarly refer the individual's need for self-knowledge, self-enhancement and self-improvement, discussing how the individual will employ self-verification strategies to achieve these. It could be argued that from this broadly functionalist perspective, the social context is a fixed and unilateral sounding board against which individuals cognitively check their knowledge and understanding of themselves and the world around them.

A shift towards alternative interpretations of self and individual is perceptible in the literature as understanding how individuals create, convey and share meaning, has become an increasingly central concern for studies on self, identity and society (Knights & Wilmott, 1999). Increasing recognition by psychologists of the need to expand beyond cognitive and behavioural analyses of self has led to the emergence of disciplines such as social psychology and social cognition (Banaji & Prentice, 1994; Stryker, 1991; Zhao, 2005), as reflected by Callero (2003, p.128), "we find a deeper

appreciation of the historical, political and sociological foundation of selfhood and a more sophisticated understanding of the relationship between self and social action."

Collin (1996) highlights how interpretive and critical perspectives reconceptualise the individual as socially constructed and contextual. The traditional western conceptualisation of the individual in society has been referred to as the 'transcendental self' (Collin, 1996; Holstein & Gubrium, 2000), a contemplative cognitive and philosophical stance where self is removed from the everyday, lived experience. The challenge to this 'transcendental self' came from a group of American sociologists (William James, Charles Horton Cooley and George Herbert Mead) taking a radical stance towards self as a social process (Callero, 1991; Cerulo, 1997; Holstein & Gubrium, 2000; Howard, 1991) by focusing on the 'empirical self' in terms of how individuals interact and interrelate, managing relationships with each other in the 'practice' of ordinary living; self embedded in experience.

2.4 Identity: a relational, social process

Holstein and Gubrium (2000) summarise the work of James, Cooley and Mead in their discussion of the formulation of a social self. They present William James as the first to challenge the transcendental self by firmly locating self in the everyday experience, recognising individual reflexivity or awareness of self through the use of language; terms of reference such as I, Me and Myself, "commonplace communicative markers of the experiencing self" (ibid. p.24), that convey subjectivity and objectivity. James's self is social, spiritual and material; reference points through which self is defined. Charles Horton Cooley similarly presents the everyday self arguing for the natural self that exists from birth subsequently developing into a social self through experience, reminiscent of Berger and Luckmann's (1991) primary and secondary socialisation. Self-feeling is central to Cooley's theory as primarily instinctive but also "shaped and transformed with our experience in the world" (Holstein & Gubrium, 2000, p.26).

This shaping occurs through reflection and reaction when responding to others, a "looking glass self" (ibid. p.27) where outward appearance, reactions to appearance and feeling towards those reactions are pulled together by the individual to create their sense

of self. However, it is George H. Mead who gives prominence to self as "socially symbolic and reflectively interactive" (ibid. p.27) above the natural and instinctive aspects to which James and Cooley refer. Mead "attributes our very personhood to social forces that shape us and our behaviour" (Crotty, 2003, p.74) arguing that human beings are social objects, defined through action, communicated by symbolic gestures and language that are given meaning and interpreted by individuals in relation to generalised others; that this begins in childhood with imitation and role play and continues into adulthood thus resulting in "selves that are collectively, not individually, structured. Together with the idea of the generalised other, Mead gives us an empirical self that is reflexively conscious of the working organisation of roles that constitute it as social structure" (Holstein & Gubrium, 2000, p.31).

Significantly, the "Chicago School" of American sociology, as epitomised by the aforementioned scholars, greatly influenced scholarship on self and identity paving the way for new interpretive epistemological and methodological approaches to the subject, such as symbolic interactionism and social constructionism. It was Mead, founder of symbolic interactionism, who originated the idea that "the self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience" (Mead, 1934 cited in Holstein and Gubrium, 2000, p.15). By its very nature, "symbolic interactionism orients to the principle that individuals respond to the meanings they construct as they interact with one another. Individuals are active agents in their social worlds, influenced by culture and social organisation but also instrumental in producing the culture, society and meaningful conduct that influences them" (Holstein & Gubrium, 2000, p.32). Mead's seminal work culminates in a general agreement that individual subjectivity (inner) and objectivity (outer) are integral to the ways by which we refer to self, others and our world in general and therefore to the processes of creating and recreating a sense of self and identity.

The symbolic interactionist view is self as a "product of social interaction" (Callero, 2003) that is multilateral and reciprocal. In other words, an individual, through interaction with others, is both defined by the interaction whilst also defining the particular social setting in which that interaction takes place. Stryker (1991), in his exploration of identity theory and the relationship between self and society, argues

"society shapes self which in turn shapes social behaviour" (ibid. p.22). It is the recognition of the individual as both object and subject whilst interacting within the cyclical relationship between self and other that emerges as central to a contemporary understanding of the socially constructed self. This process, the way in which it is managed, controlled and presented is reflected in subsequent classic texts on self and identity (Berger and Luckmann, 1991; Goffman, 1990).

Sluss & Ashforth (2007) refer to the conventional focus on the dyad of individual and collective in much of the identity literature. When using 'individual' as a reference point, it is immediately placed dialectically with 'other'; 'group'; 'society' or 'collective' in terms of how the two elements relate to one another. Similarly, reference is made to the inner and outer self, the private and public (Callero, 2003; Goffman, 1990). This convention derives from social constructionism, the understanding that all knowledge and meaningful reality is contingent on human practice, constructed through interaction and conveyed, developed and transmitted within particular social contexts. Fundamental to this is the notion of intentionality, the interdependence of subject and object, "a quite intimate and very active relationship between the conscious subject and the object of the subject's consciousness" (Crotty, 2003, p.44). For the social constructionist, human beings are born into a world of meaning that is taught and learnt through processes of socialisation and enculturation, shaping thought and behaviour (Crotty, 2003).

In their classic text, The Social Construction of Reality (1991), Berger & Luckmann argue that whilst human beings objectively exist within the natural world, they only 'become' people through social interaction with others and it is through such interaction that social worlds are subjectively constructed. Objective reality exists at a level of primary socialisation, the first interactions an individual has with their world from birth, where objective truths are presented and thus become reality; for example, a hungry baby learns that milk relieves hunger. Only as the baby grows and develops does secondary socialisation occurs. Here, with a developing sense of self, an increasing awareness of the environment and interaction with others (both 'significant' i.e. mother/father and 'generalised' i.e. society), the child begins to challenge those initial objective truths i.e. it is not just milk that assuages hunger. Berger and Luckmann (1991)

propose that an individual externalises self into a social world objectively, whilst also internalising these experiences subjectively. Some experiences are 'routinised', habitual actions (sleeping, eating) often occurring at an individual level, whilst others become 'institutionalised', habitual action which becomes 'typical' for groups of people and that these groups share meaning, norms, values and rules to create and maintain a particular social order. A key point they make is that this institutional order can only be understood in terms of the knowledge that group members have of it, i.e. their meaning and interpretation, which is conveyed through language, "the instrument of the collective stock of knowledge" (ibid. p.86) and other symbolic tools. Collin (1996, p.12) describes the social constructionist viewpoint as,

> The making of the individual takes place in the daily engagement with other people, in interpreting and negotiating with others' expectations and behaviour. The individual constructs and learns to project an identity that is expected or desired in a given situation and that makes actions meaningful and acceptable to, and largely predictable by, others. In doing so, each individual plays a part in forming the identity of others: in constructing self through interaction with others, the individual is also constructing society.

Cerulo (1997) highlights the trend towards social construction of identity as a more viable basis of defining self, illustrating how the literature, post 1970's has moved towards collective identification, defining this as "the 'we-ness' of a group, stressing the similarities or shared attributes around which group members coalesce" (ibid. p.386) as the way by which self is formed and maintained. As with Berger and Luckmann (1991), she argues it is collective agency that creates and maintains the environment in which people interact.

Reflexivity and agency are important features of the interpretivist perspective on self. Reflexivity "refers to the uniquely human capacity to become an object to oneself, to be both subject and object" (Callero, 2003, p.119) and it is the reflexive process of social interaction that "allows for agency, creative action and the possibility of emancipatory political movements" (Callero, 2003, p.120). In other words, individuals, both singularly and collectively, are actively involved in managing, controlling and legitimising their

social environment. This is reminiscent of Goffman's analogy of individuals as actors, managing their performance for a chosen audience (Goffman, 1990). Agency, the extent to which an individual is central to and proactive in identity construction, is fundamental to an understanding of identity, particularly when considering the process of identification at a collective level. Cerulo (1997, p.393) argues for collective agency commenting that "identities emerge and movements ensue because collectives consciously co-ordinate action; group members consciously develop offenses and defenses, consciously insulate, differentiate and mark, cooperate and compete, persuade and coerce; in such a context, agency encompasses more than the control and transformation of one's social environment."

Goffman's (1990) classic text on the *presentation of self* encapsulates the central role of agency in identity work. Writing from a sociological perspective and within the context of institutional life, Goffman's dramaturgical analysis offers a different way of looking at social systems, alongside technical, political, structural and cultural analyses; he extended his work to sociological observations of patients in psychiatric hospitals (Goffman, 1961), an institutional perspective that has pertinence to health care organisational research. The social constructionist view of multiple identities, the dyads of individual/collective and self/other (Berger & Luckmann 1991) are prevalent in Goffman's analysis. He argues that individuals are social actors, engaged with multiple roles, wearing different masks and putting on different performances for a range of audiences; this has salience for my study of role in an organisation.

These performances are enacted across 'front of stage' and 'backstage' settings, physical, symbolic or psychological locations which are temporally and spatially bounded. Each mask presents specific behaviours, language, gestures and expectations relating to a social role. Individuals act to "intentionally or unintentionally express themselves; others are then impressed by what they see" (ibid. p.14). Through action and gesture, individuals present an idealised impression of their social role "which comes to be accepted as reality" (ibid. p.45). In other words, the individual presents a 'front' in appearance and manner to fit with the role in question, for example, the corporate image of businessman in tailored suit. However, it is not just the individual actor who is involved in this enactment.

Goffman argues that others co-operate to confirm the performance and it is this collective "teamwork" of dramaturgical co-operation that maintains and manages the presentation of a specific image. Collectively, team members are reciprocally dependent on one another to perform in an acceptable and agreed manner, within agreed rules of conduct and behaviour, thus presenting a cohesive front; working together to agree and maintain the "party line" and hence become institutionalised (Berger & Luckmann, 1991). The image presented publicly may differ backstage where team members may "drop the act" out of public view. Goffman asserts that teams must protect the performance they give hence deploy strategies of dramaturgical loyalty (team members supporting one another), discipline (individuals know the part they play and perform it as expected) and circumspection (being prepared for any eventuality, observing protocol) in order to maintain the public impression they have constructed. In short, Goffman's framework links individual, social interaction and society through dramaturgical analysis,

> Social establishment is in a setting, derived by team members, audience, outsiders and interactions between them. These interactions are performed according to agreed and shared standards, behaviours and impressions thus *defining* the social experience. The setting/stage has front, back and outside spaces within it. Impression management maintains the social establishment until disrupted by unexpected, disruptive anomaly; non compliant events/actions occur challenging and possibly discrediting the situation being presented.
>
> (Goffman, 1990, pp.234-5).

The question that arises is the extent to which the individual maintains control and independence during interaction with others as opposed to being subsumed within collective action or as Brown (2001, p.114) asks, "one key issue here is how, and to what extent, individuals come to construct their social identities in terms of the social categories to which they subscribe?"

The concept of self as socially constructed (Mead, 1934; Berger & Luckmann, 1991) has salience with my research as I explore the ways by which individuals singularly and together create, define and enact the role of Modern Matron, a senior nurse position in the English NHS; similarly, Cerulo's (1997) observations on collective agency have resonance when considering the role of Modern Matron as performed by more than one individual within the organisation; the question arises as to how these individuals relate to one another, work together and, by doing so, create a collective identity. Goffman's (1990) conceptualisation of "front of stage" and "backstage" is of interest when considering how individual Matrons present themselves to others, singularly or when acting as part of a group; in the complex organisational setting of an NHS Trust, there are multiple 'audiences' with whom the Matron[s] interact. It is pertinent then to review theoretical propositions on how identity "becomes" through social interaction.

2.5 Developing Identity: the social self

There are numerous theories on identity that have relevance here as ways by which to "understand and explain how social structures affect self and how self affects social behaviours" (Stryker & Burke, 2000, p.285). Building upon Mead's framework of society shaping self, which in turn shapes social behaviour, identity theory (Stryker, 1991), and social identity theory (Ashforth & Mael, 1989) present a social psychological view on how and why identities are formed, managed and maintained. Both theories agree that the self is reflexive thus able to objectively categorise against other social categories and events. Both theories assert that identity formation and maintenance exists within a structured society, thus implying that self is a stable and bounded concept within a structured environment, and both theories focus on salience, i.e. more conspicuous and easy to relate to, as an important factor in the process of identification at a social, collective level.

Where the two theories differ is that identity theory focuses on role identity, *what one does*, whereby the individual occupies and incorporates self into multiple roles, performed through negotiated meanings and expectations; it considers the multiple roles that an individual can occupy, asserting "role choices are a function of identities" and

that "social roles are expectations attached to positions occupied in networks of relationships; identities are internalised role expectations" (Stets & Burke, 2000, p.286). In other words, if a social role closely aligns to an individual's internal view of self in terms of values, beliefs and expectations, it will have greater salience and therefore the individual is more likely to commit to the role, thus taking affirmative action towards self-identification.

Meanwhile, social identity theory focuses on group identity, *who one is*, which considers where an individual belongs and how an individual is labelled according to group membership and where uniformity of perception across members is significant in maintaining the group identity (Stets & Burke, 2000). Sluss & Ashforth (2007, p.16) describe this as "individuals interact based on group prototypes rather than personal characteristics" with emphasis on understanding the extent to which internal self-identity (individual) produces the requisite behaviour and shared meaning required for role enactment within the social network. This is reminiscent of Goffman's (1990) analysis of teamwork and the strategies employed by individuals and group members to coalesce in presenting a stereotypical and united 'front' performance. Horton (2006, p.534) explains social identity theory as follows,

> Group membership creates in-groups and out-groups and individuals derive positive self-esteem and status from being a member of the in-group. In fact, people's sense of who they are is defined by reference to "we" rather than "I." However, if identity with the in-group no longer confers status, or there is a change in the goals, values and principles on which the individual perceives the group to be based, then individuals will disassociate and transfer to another group where personal identity once more confers status.

Ashforth and Mael (1989) argue that social identification occurs as individuals classify themselves and others into groups based on their own self-perception, values and attitudes relative to the perceived characteristics of the group, thus gaining a shared identity. An individual can belong to many groups hence can "retain multiple identities" (Ashforth & Mael, 1989, p.23).

Brewer (2001) analyses the 'many faces' of social identity, distinguishing between different meanings of social identity in four ways: *person based*, located within the individual's concept of self and particularly influenced by fact of membership to group[s] such as gender and race; *relational*, located within the individual's concept of self in relation to their role[s] in relation to others such as parent – child or doctor - patient; *group based*, identification with the in-group through common and shared ties, a cohesive presentation in contrast to others and *collective,* representing the achievement of collective effort to create and shape an idea of what the collective is, above and beyond the initial shared ties of its members. In distinguishing between the types of identity, Brewer (2001) argues that person based and relational identities are "selected and activated by the individual" whilst group or collective identities are "elicited by the social context" (ibid. p.121). She concludes that "all social identity theories share the recognition that individuals can, and usually do, derive their identities from more than one social group" (ibid. p.121), and argues that the dynamic interplay between the dyad of individual (me) and collective (we) is equally balanced.

Sluss & Ashforth (2007) consider the levels of identity highlighted by Brewer (1996, 2001) agreeing that identity derives from each level but in different ways, according to situation, values, goals and expectations. However, they argue that the relational level, focusing on role relationships, is under-explored and yet has significant potential for organisation studies,

> In the face of environmental turbulence, the emphasis on traditional bureaucratic structures and control systems is shifting toward more fluid team and project-based work, where interaction and personal connection provide relatively informal social controls…identities and identifications drawing from role-relationships may provide a much-needed cognitive and affective glue for organic organisations.
>
> (Sluss & Ashforth, 1997, p.10)

They define relational identity as the nature of interaction between roles (e.g. manager – subordinate) whilst relational identification is concerned with the extent to which an individual defines self in terms of the role relationship.

Where relational identity differs to social identity theory is in the degree of personalisation that occurs through interaction in the role-relationship. Whereas social identity theory suggests individuals interact on the basis of group prototypes, thus depersonalising the individual self, relational identity works in opposition to this, where interactions between roles are based on personal characteristics and become increasingly personalised over time. Through their detailed analysis of the interactions within role relationships, highly personalised, characterised by interpersonal attraction and capable of transcending beyond role to deeper connections between individuals in friendship, Sluss & Ashforth (2007, p.27) conclude that the constructs of relational identity and relational identification "offer a fruitful perspective for understanding how individuals define themselves within organisational contexts."

Theoretical approaches to identity as described above bring attention to the way in which individuals singularly and collectively derive identity, through interaction and generation of shared meaning either in terms of what one does (role) or who one is (group). A key focus is the nature of these interactions, the extent to which individuals proactively construct meaning and define the role(s), group(s) or collective with which they interrelate or vice versa. There is consistency across the various theories that an individual can have multiple roles and/or multiple identities that are enacted across different levels (macro/micro), in different locations (spatially) and different time-spans (temporally). Identity as an analytical frame is increasingly pertinent to organisation studies as "organisation scholars are increasingly concerned with organisational, managerial, professional and occupational identities, as well as how organisational members negotiate issues surrounding self in workplace settings" (Alvesson et al., 2008, p.5).

My research presents an opportunity to explore social identity construction through the role of Modern Matron; of particular interest is the idea of multiple identities occurring at different levels (Brewer, 2001) through the dynamic inter-relation of self with social context. Relational identity and identification (Sluss & Ashforth, 2007) has pertinence as

I consider how the individual Matrons define themselves and interact with others in the organisation whilst collective identity construction (Cerulo, 1997) is also of interest when considering the Modern Matrons working as a group. However, before moving to a more specific consideration of identity in relation to Modern Matrons in the nursing profession, some further reflection on the identity literature is required.

2.6 A Critical Perspective on Identity

Up to this point, the review of the literature has focused on self and identity from classic perspectives of symbolic interactionism and social constructionism, presenting the view of self and identity as emergent from inter-relations between the individual and others, socially determined, contextually derived and thus multiple, fluid and ever-changing. More fundamentally, it is assumed that the empirical self is "a concrete element of society…a constant agent of everyday life" (Holstein & Gubrium, 2000, p.56). As always, this assumption can be challenged and consequently has been within critical literature on identity.

Cerulo (1997, p.387) notes the shift towards collective identification where "every collective becomes a social artefact – an entity moulded, re-fabricated and mobilised in accord with reigning cultural scripts and centres of power" but recognises the irony implicit within this, that by assuming homogeneity in the collective, as presumed by social identity theory, there is a risk of essentialism, the very thing that interpretivism aims to avoid. Alvesson et al. (2008) agree with such concerns, giving a cautionary note that whilst distinctions between individual and group, self and other, personal and social are inevitable, they are also prone to arbitrary categorisation, becoming fixed, boxed and packaged, thus become antithetical to the interpretivist roots. Emphasis on the social above the individual is problematic and potentially dangerous, the "dark side" of the social self, where conforming to collective norms and values is at the expense of the individual, and damages individual identity (Holstein & Gubrium, 2000).

Brown (2001), in his discussion of organisation studies and identity, elucidates the problem further explaining how identity theories have concentrated on processes of

identification, for example, self conception and self presentation but have taken "such a broad brush approach that the subtleties and complexities of the dynamics of these processes have rarely been adequately captured" (ibid. p.115). Brown argues that more needs to be done to understand the conditions under which the individual will identify or resist identification with a particular social group, suggesting that "subjectively construed identity is a power effect, a complex outcome of processes of subjugation and resistance that are contingent and perpetually shifting" (ibid. p.115).

Callero (2003) specifies three organising concepts in his analysis of the sociology of the self, namely social constructionism, reflexivity and power. He highlights how the social constructionist perspective emphasises the public self over the personal self giving rise to hybrid identities, "where local and global meanings are not segregated but exist in a multiple, dynamic and conflicted relationship" (ibid. p.123) and that the symbolic interactionist view of self as a reflexive process is useful in understanding how these meanings and understandings are constructed and social behaviours determined. At this point, however, Callero diverts from the symbolic interactionist interpretation towards a critique of self, where self is no longer regarded as a bounded, structured object but deconstructed to exist only as "a fundamentally social phenomenon where concepts, images and understandings are deeply determined by relations of power" (ibid. p.127) conveyed through language and discourse.

The critical perspective on self and identity is articulated as an antithetical response to the essentialist perspective of modernism and conventional debates on universality, structure and agency, individual and society within it. Theoretically, the modernist perspective holds that there is a pre-existing and defined order and structure within which humans act; from a critical perspective, self and identity are variously and temporarily defined through human action, occurring at different times and in different spaces as part of an ongoing, ever-changing process of becoming (Cooper & Burrell, 1988; Crotty, 2003; Rattansi & Phoenix, 2005; Taylor, 1998); to take this view requires one to accept the tentative, partial and emergent nature of conclusions drawn about identity.

Self-construction is no longer regarded as one-dimensional, with singular interpretation and meaning attributed to the question of "who I am", it becomes deconstructed, with a myriad of interpretations and meanings, all variable, highly contextual and different thus shifting the question to "where, when and how am I?" (Holstein & Gubrium, 2000, p.105). Côté (2006) explains it is important "to see identity as "decentred" and "de-essentialised" in contemporary contexts, meaning that "identity" is not primarily a property of persons, but rather of interactional processes which are now inherently unstable" (ibid. p.13) or as Holstein and Gubrium (2000, p.68) write, the self "can no longer stand as a grounded source or object of experience."

Critical analysis of self and organisation gives consideration to what is different, unknown, outside and apart from that which is already known and organised (Cooper & Burrell, 1988). Rattansi & Phoenix (2005, p.103) claim identity acquires "meaning and significance in relation to difference, that is, in relation to what it is not" thus focusing attention on 'relational difference' and oppositional issues such as power, resistance and contradiction. Self-reference occurs through actions taken in reaction to difference. They specify several "intellectual moves" (ibid. p.103) that characterise critical conceptualisations of identity, including de-centring of self, deriving meaning and significance in relation to difference, an individual having multiple, hybrid roles and the significance of narratives and representations in identity formation. These intellectual concepts derive from the works of key Western philosophers including Nietzsche, Derrida, Lyotard and Foucault.

Friedrich Nietzsche argued against modernist assumptions of objective truth and universality believing instead in multiple truths and realities that are diverse, fluid and contextual. It is Nietzsche who first commented on power to be the real motivator for people's actions and difference as central to self-reference and identity; that self-reference occurs through actions taken in reaction to difference (Cooper & Burrell, 1988; Wicks, 2008).

Jacques Derrida extends this thinking with his writing on *différance*, believing meaning to be "founded as much on the absence of what it is not as on the presence of what it is" (Crotty, 2003, p.207). For Derrida, difference is about deconstructing what is known to

illuminate and understand the unknown, and this is revealed through text and language. Individuals relate and communicate with one another using language but the words used in such communication will only acquire meaning and significance when placed in relation to other words. It is the difference between the words that signifies meaning. From Derrida's view, language is contextual, historical and temporal and consequently, meaning is fluid, transient and never finalised.

Jean-François Lyotard also considers language to be central to understanding self. He criticises the modernist grand narratives of determinacy and emancipation, arguing that they have lost credibility and that it is micro narratives, occurring locally and contextually specific which emerge as important and meaningful in the formation of self and identity. Within these micro-narratives, Lyotard refers to the play of "language games" where "in practice, self and its associated vocabulary are a living language game, applied to locate and define who we are as individual members of society" (Holstein & Gubrium, 2000, p.84).

Michel Foucault's primary intention has been to focus on the subject and subjectivisation, and how this occurs through relations of power. Foucault (1982) believes power relations are rooted in social networks which are contextualised by history and constructed through interaction, that "power exists only when put into action" (ibid. p.777), and argues that to understand the nature of power one needs to focus on resistance, echoing once again difference as central to understanding self. As with Derrida and Lyotard, Foucault believes that self and subject derive from narrative discourse, that "the self no longer references an experientially constant entity, a central presence or presences, but rather stands as a practical discursive accomplishment" (Holstein & Gubrium, 2000, p.70), thus it is through language, text and words that the self is constructed. Foucault speaks of discourse as meaningful action, a system of understanding, meaning and significance that controls and regulates action thus discourse is power and knowledge (Foucault, 1971; Holstein & Gubrium, 2000).

In relation to self and identity, the work of the above scholars has led to a significant challenge on traditional thinking on subject, agency and action. Whereas the socially

constructed empirical self exercises choice, autonomy and intentionality during social interactions, the critical self becomes a passive subject, a "site of discourse of power and knowledge" (Caldwell, 2007, p.770) and "essentially an observer-community which constructs *interpretations* of the world, these interpretations having no absolute or universal status" (Cooper & Burrell, 1988, p.94). The emphasis shifts from agency as central to the construction of self and identity within the constraints of a given social structure towards a social world shaped by language, discourse and power (Houston, 2001). The literature suggests identity is shaped by relations of power, discursively revealed through social interactions between individuals and groups and through compliance with, or resistance to, such forces. This has relevance to my research as I consider the relational aspects of Modern Matron identity construction.

One prevailing area of contention with the critical perspective is the tendency toward complete relativism (Houston, 2001) as, by decentring agency and refuting the notion of an empirical self, the argument concludes that self, as an experienced, real entity cannot exist. This sceptical/radical standpoint argues instead for the possibility of becoming through continual construction and negotiation of human action, governed by driving forces of power, resistance and control, communicated through language and discourse. A less nihilistic view is to acknowledge the reality of experience with the belief that this is so diverse and complex it leads to a self that is multiple, hybridised and with many representations rather than one centred self (Holstein & Gubrium, 2000; Houston, 2001). Whilst this affirmative stance goes some way to respond to the criticism of complete relativism, it is still regarded by modernist scholars as inconsistent "because relativistic assumptions are logically incompatible with any form of prescribed direction no matter how tentatively expressed" (Houston, 2001, p.849).

Caldwell (2007) suggests that whilst the criticism levelled at decentring agency and rejecting self is valid, it is worth considering the value that a critical perspective has brought to scholarship on self and identity in that "it allows new possibilities" (ibid. p.771) for interpretive analysis of organisations and societies. One such possibility is the focus on language and discourse as a device for constructing and analysing identity.

2.7 Discourse: a device for constructing and analyzing identity in organisations

As has been illustrated above, language, its construction and use, is an important phenomenon and the central idea that self and identity are discursively constructed results in discourse as a burgeoning theoretical and methodological approach (Grant et al., 2004). Sveningsson and Alvesson (2003) speak of discourse having "both an ideational/ideological and practical/structural element" (ibid. p.1172). Discourse is variously defined, given many different meanings and applied in different ways, across diverse settings. Alvesson & Karreman (2000) suggest that discourse is broadly referred to either as an empirical study of social text, i.e. talk and written text in everyday action on the one hand or as a systemic study of social reality, constructed through historically situated and powerful language. This latter view of discourse is typically Foucauldian whereby the term is used "to refer to interrelated sets of texts that systematically form the objects of which they speak" (Foucault, 1972, p.49 cited in Ainsworth & Hardy, 2004, p.154).

It is this view that has emerged as the classic approach to discourse studies fundamentally assuming that knowledge is discursive in nature, created in language and a direct consequence of power thus discourse regulates and controls relations between individuals (Dick, 2004). Foucault refers to "grand discourses" such as class and gender as "fields of power" in which subjects are positioned, constructed and disciplined. From this perspective, discourse analysis, which focuses on text and language, how it is used, interpreted and understood becomes prominent, both theoretically and methodologically (Ybema et al., 2009). Discourse analysis provides a way by which to examine the complexities of identity construction processes continually at play, "a discursive perspective, by situating collective identity in the language in use among members, shifts attention from the intentions and attitudes of individuals to their observable linguistic practices and the effects of these practices on social relationships and action" (Ainsworth & Hardy, 2004, p.155).

Fairclough (1992) suggests that discourse constitutes the identity of individuals, relationships between individuals and ideological systems that exist within society and

that across these domains, discourse can be analysed in three ways: as text, the written or spoken word; as discursive practice, the context and interpretation of text in use and; as social practice, the multiple and varied discourses that exist within society, reflecting "the process through which contested views of reality are dealt with in order to secure ideological consent" (Dick, 2004, p.205). Alvesson and Karreman (2000) refer to discourse encompassing language, cognition and subjectivity, along two dimensions of discourse/meaning and macro/micro levels. Their framework emphasises the link between language use and its interpreted meaning along a range from tightly to loosely coupled as well as being analysed according to scope and scale, both situational and locally specific at a micro level or "beyond specific", the long range, overarching macro-system level, where text and talk becomes embedded in the social system as meta-narrative. They make the distinction between 'discourse', at the micro level and 'Discourse' on the macro level, arguing that it is the methodological considerations of empirical study that determine which of the dimensions within the framework are chosen when analysing discourse in organisational research.

Grant et al. (2004) also present a framework for understanding and analysing discourse according to three different "modes of engagement." First, domains of discourse, the ways in which text, "the manifestation of discourse", occurs: as conversation, narrative and stories, rhetoric and tropes; second, methodological and epistemological perspectives that inform "the study of organisational discourse" such as language in use and context sensitive research methods; and third, discourses and organising, the analysis of organisational phenomena, such as gender, power and culture using discourse as an analytic lens. In effect, this framework mirrors Alvesson & Karreman's micro/macro distinction, where organisational phenomena occur at a macro level creating a meta-narrative or grand Discourse within which other micro domains (text, language in use etc.) are situated. In an attempt to define 'discourse', these frameworks reveal its complex nature as it occurs across many dimensions and levels, within different contexts, across time and space.

Broadfoot et al. (2004) speak of the diverse, multiple and contradictory nature of discourse in relation to organisation, referring to the "relationship between the processes

and products of discourse and organisation" (ibid. p.193) as a "complex and vivid picture" (ibid. p.194). They argue that the dualisms of process/product, macro/micro, discourse/meaning need to be considered holistically as one directly influences and impacts on the other, "macro-level discourses-as-structures can be seen as existing only to the extent that they are endlessly reproduced in the language and knowledge resources deployed by individuals engaged in organising processes" (ibid. p.194). Ybema et al. (2009) also refer to the meta-narrative or macro level discourse as structural, versus micro level talk as agential, thus bringing the agency-structure dialectic found within identity literature to the fore. The literature on discourse conveys the social constructionist perspective of duality, suggesting a symbiotic relationship between discourse, organisation and identity.

The link between identity, discourse and organisation is articulated across the literature (Ainsworth & Hardy, 2004; Sveningsson & Alvesson, 2003; Ybema et al., 2009) situating identity as "a lynchpin in the social constitution of self and society" (Ybema et al., 2009, p. 302). Dualities of self and other, seen and unseen, agency and structure are discursively performed by individuals, through identity talk, within multiple and contradictory societal meta-narratives which in turn provide structure for organisation. Broadfoot et al. (2004) write of discourse as a combination of historically specific and temporally bound discursive formations, practices, fields and apparatus working together to produce objects, subjects and relationships. They argue that "examining the practices and processes through which discourses become articulated together and their grounding in the interdependent nature and role of institutions and individuals provides a useful way to think about organising phenomena from within a theory of discourse" (ibid. p.197).

Ainsworth & Hardy (2004, p.160) also refer to the interdependence and mutuality between discourse and identity, describing how "research on talk and identities has shown how the rules and structures associated with interactions in a particular setting help to constitute identity; how these rules and structures can be used strategically; how locally situated talk enacts broader social structures in the form of organisational and

institutional identities." As has been shown, discourse is at the epistemological core of an understanding of self and identity. As Grant et al. (2004, p.25) summarise,

> Organisational discourse has made several important contributions to our understanding of organisation. Most notably, it has shown how discourse is central to the social construction of reality and, more specifically, as part of this process, the negotiation of meaning. As such, discourse 'acts as a powerful ordering force in organisations' (Alvesson & Karreman, 2000, p.1127). Discourse analytic approaches therefore allow the researcher to identify and analyse the key organisational discourses by which ideas are formulated and articulated and to show how, via a variety of discursive interactions and practices, these go on to shape and influence the attitudes and behaviour of an organisation's members.

With this in mind, it is appropriate to consider the discourses that exist within a chosen field of organisational research, in my case, policy implementation within a health care organisation. What these discourses are, how they are presented and what meaning is derived through them can only be revealed through analysis of empirical data. It is evident from the literature that one might expect a variety of discourses, "cultural scripts, professional rhetorics, management discourses, every-day talk or shop floor narratives" (Ybema et al., 2009, p.302) to emerge.

2.8 Concluding Thoughts

This literature review has focused on both theoretical and methodological issues pertaining to identity and related concepts within organisational research. A critique of different epistemological stances has been given, with reference to classic scholarship and critical texts. Identity has been presented as socially and discursively constructed, intricately bound by dualities of self and other, subject and object, individual and collective, structure and agency. The contested nature of such dualities, through relations of power, resistance and difference has been presented, and the complexity of

social interaction and inter-relations that actively construct and give meaning to the social, organised world discussed. Emerging from this critique is the belief that it is language that enables individuals to share knowledge and meaning; discourse as theory, and discourse analysis as method emerge as essential to understanding organisations, individuals and the inter-relations between them. Identity and discourse are presented as useful analytical lenses for qualitative organisational research and this literature review has laid the foundation for critical analysis of my empirical data.

The identity literature offers various avenues of exploration for my data. I am particularly interested in the social identification processes that occur as individuals perform in their role as Modern Matron through interaction with others. These 'others' are organisationally situated 'above', 'beside', 'below' and 'beyond' the Modern Matron role which presents a multitude of role-relationships to be defined, managed and mediated through discursive acts of power, authority and autonomy, and deriving from meta-narratives of organisational and professional discourse. Given that my research focuses on a nursing role as it is performed in the workplace, an English NHS Trust, the following chapter considers the literature on professional identity, and in particular, professional identity in nursing.

3 PROFESSIONAL IDENTITY

As highlighted in the previous chapter, a "dynamic account of identity" (Whitchurch, 2009, p.376) which considers both structure and agency is helpful in understanding role and identity within the workplace. Individuals enact roles in organisations which are interactive, subjectively and socially constructed, placed in relation to collective identity of shared purpose and values and from which professional identity emerges (Macdonald, 2006). Professional identity becomes a facet of self and identity work, "one of the multiple social identities that an individual holds" (Hotho, 2008, p.729).

An exploration of the literature on professional identity gives theoretical insights to the processes of identification and performance of professional roles. This is of particular relevance to this research which focuses on the introduction of a new senior nursing role, the Modern Matron in the English NHS. The picture is complex with inter-relations between macro-level influences such as government policy; meso-level issues such as organisation and structure and micro-level concerns of the individual in creating, defining and identifying with the Modern Matron role.

3.1 Defining professional identity

To be able to discuss professional identity we must first try to define it. It occurs across a broad range of literature in various guises; being part of a profession; being a professional; the process of becoming professional, professionalisation; and the emergent discourse of professionalism (Evetts, 2003a; 2005; Fagermoen, 1997). Professions tend to be considered as high status occupational groups distinguishable from other occupations by greater degrees of autonomy, power and authority (Hughes, 1963; McMurray, 2010). Macdonald (2006) writes about professional work, defining it as knowledge-based expertise. A professional is an individual who, through their knowledge, expertise and experience has greater command, control and autonomy over their work and the people they administer to, winning support and trust as they interact with others. To be a professional is to hold a position of prestige within society. A profession therefore is a group of individuals who share this specific knowledge, expertise, values and characteristics. Davies (2002, p.34) explains,

> Expertise lies at the heart of most conventional understandings of professionalism. It derives from a lengthy process of acquiring a body of knowledge which is widely acknowledged to be complex, worthwhile and important. Professionals are accorded respect by virtue of their possession of this knowledge. The process of becoming a professional has instilled in new members a special sense of trustworthiness.

Archetypal examples are the medical and legal professions (Hotho, 2008; Sommerlad, 2007), both of which require education, vocational training and demonstrable experience in order to practice professionally and become a member of an elite group with significant societal, political and occupational power and control. In her sociological analyses, Evetts (2003a; 2003b) suggests that historically, professionalism had been regarded as a control mechanism, contributing to Weberian functionalist ideals of social order and stability whereby collegial organisation and shared collective values had a normative effect. By considering professionalism as a normative value system, the professional becomes distinct from the lay person, holding a position of authority, gaining higher societal status and privilege in return for imparting their valuable knowledge and expertise appropriately and in what is presumed to be a trustworthy manner.

Professionalism as described above has been criticised for its promotion of monopolistic elitism which favours a 'powerful and privileged few' (Evetts, 2003b, p.401); that expertise harnessed within a profession creates power and authority which leads to a position of dominance, thus emphasising "knowledge as an important technique of power" (Mackey, 2007, p.97). Freidson (2001) refers to Weber's notion of social closure, exclusive membership to a group, as an essential mechanism for preserving the integrity of the professional group. Professional groups have collective power, have license to restrict entry to the group and, as consequence, restrict the right to practice to those within the group.

Goffman's (1990) socialisation process and Ashforth and Mael's (1989) in-group behaviour help to explain how professional groups manage social closure, through shared beliefs, values and action. It is the professional in-group that "lays down rules

and procedures, assigns roles and positions and regulates behaviour and communication" (Mackey, 2007, p.98); a Foucauldian approach to self-regulation whereby individual behaviour is internally regulated to comply with and meet the expectations of the collective group and society as a whole. Mackey (2007) talks of turning the "professional gaze" inwards (ibid. p.98) to describe how the profession acts autonomously, internalising values, language and self regulating behaviours in order to create a discourse of professionalism, something Fournier (1999, p.281) describes as "a device for occupational control." Professional identity emerges from the elevated position of expert in relation to layperson, founded on credentials attesting to specialised knowledge, which in turn creates a position of power and dominance demonstrated through language and action, reiterating a discourse of professionalism.

Mintzberg (1979), in his discussion of the structuring of organisations refers to the professional bureaucracy, typified by 'highly trained specialists'; professionals providing the main 'business' of the organisation; establishing their own standards of practice; self regulating and autonomous. This autonomy enables them to control their own work and have collective control of administrative functions in the organisation, as these are arranged to directly support professional practice (managers supporting professionals). The knowledge held by professionals is complex, with demonstrable competencies attained through specialist and extensive training and forms the basis of the professional monopoly they hold. Meanwhile, Evetts (2005) differentiates between types of professionalism, namely occupational and organisational. Occupational professionalism is as described above, whereby the professional group forms, controls and regulates actions and behaviour using collegial authority, an internal process of professionalisation. Organisational professionalism describes a discourse of control and authority along principles of universality and accountability, an external *management of* the professional group "from above" rather than internal *management by* the professional group "from within" (ibid. p.7). Meulenbergs et al. (2004) refer to this as external institutionalisation, characteristic of a post-professional period of managerialism and economic rationality in which professions must renegotiate their codes of practice. This differentiation is particularly useful when considering professionalism in public management characterised by higher degrees of state-led control, regulation and policy.

3.2 Professionalism and Management within Public Services

The discourse of professionalism has become increasingly apparent in new public management theory and practice whereby "professionalism" is being used to motivate staff performance and reassure service users of professional competency through accountability and control mechanisms associated with regulated professional practice. This can be interpreted as a response to the perceived self-interest, recalcitrance and power of professions in and over public services which had long thwarted political/managerial attempts to control provision and the search for greater efficiency, efficacy and economy (Flynn, 2007; Pollitt, 2003). This is a different type of professionalism than that described above (Hughes, 1963).

New Public Management (NPM) has been described a series of trends towards increased managerialism, marketisation, and consumerism, theoretically underpinned by economic rationality with the overall aim to improve the efficiency and effectiveness of public service management (Dopson, 2009; Exworthy & Halford, 1999; Ferlie et al., 1996). Paulson (2006) suggests that NPM itself is an identity project as increasing managerialism and new ways of organising and delivering public services require new roles and identities for public sector professionals, balancing economic rationalism with value-laden, ethical professional practice.

NPM practices create tension between managers and professionals as the ideologies of professionalism and managerialism come into conflict (Dopson, 2009). Freidson (2001) argues that the power and legitimacy of managerialism is strengthened as neo-liberal rhetoric criticising professionalism as elitist, monopolistic, exclusive and discriminatory undermines and weakens professional credibility. In similar vein, Sehested (2002) argues that, by strengthening the external influence and control, for example, by government over the professional group, managerialism undermines the traditional power and dominance of the professional; where trust is essential to occupational professionalism, external audit and regulation are essential to organisational professionalism.

Dent & Whitehead (2002) refer to a “culture of performativity” whereby belief and trust in a person’s subjective professional judgement has shifted to trust and belief in external control systems, for example audit, governance and regulatory structures. This directly challenges traditional notions of what it means to be professional; in this culture of performativity, to be a successful professional means to perform well in the externally controlled and performance measured environment. This is a concept which has salience to my research which explores how a managerialist initiative of benchmarking, auditing standards of clinical practice, is implemented by senior nursing professionals.

Political and administrative leadership along with a democratisation of the relationship between expert and layperson threaten the specialised knowledge and expertise held by professionals. With the rise of managerialism, managers act professionally whilst professionals are both managed and manage; the traditional notion of the professional no longer exists; in its place is “new professionalism” where “being professional” takes precedence (Dent & Whitehead, 2002). Causer & Exworthy (1999, p.84) argue that the blurring of boundaries between professional and manager leads to “a continuum of roles reflecting varying ways in which managerial and professional activities relate to one another.” They propose a taxonomy of roles along the continuum; the practising professional exercising daily professional work; the managing professional who manages the day-to-day work of other professionals; and general managers, with overall management responsibility for the activities of professional staff. Within these three types, there may be further divisions between practising and non practising managers and professionals. Other commentators refer to “hybrid management,” whereby a role may span different boundaries, combining both professional and managerial responsibilities as they do so (Ainsworth et al., 2009; Bolton, 2003; Forbes & Hallier, 2006; Savage & Scott, 2004; Sveningsson & Alvesson, 2003; Whitchurch, 2008).

New public management practices, at both macro and meso levels, challenge professionals to readjust and reconfirm their identity in line with an ever-changing work environment, moving away from occupational professionalism towards a less bounded, hybrid management (Currie et al., 2010; Sehested, 2002; Sommerlad, 2007). As Exworthy and Halford (1999, p.138) point out, “managerialism will be accepted as a key government strategy for the implementation of local policy” and professionals and

managers alike will have to respond to this shift in focus. With this in mind, Dent et al. (2004, p.2) propose three ways by which professionals attempt to mitigate the impact of managerialism on their professional authority and autonomy: i) colonization, claiming a professional right to take responsibility for an activity thus gain control and influence over it; ii) de-coupling, minimizing the impact of an NPM initiative by treating it as a formality with little practical importance to their job or, iii) reconfiguration, a mix of both colonization and de-coupling strategies. The literature supports a Foucauldian analysis of professional identity as relational and constructed where "professional identity lies in the constant interplay between strategies of normalising professional power and resistance" (Mackey, 2007, p.98) as professionals negotiate their place within the reconfiguring workplace.

3.3 Professionalism and Management in Health Care

The discourse of managerialism, prevalent in public management extends to health care management as professional boundaries in health care are being "blurred, reordered and reconstituted" (Lane, 2006, p.341). To understand the implications of this on role and identity, it is necessary first to consider the dichotomous nature of professionalism within health care. On the one hand, medicine is imbued with deep-rooted traditional occupational professionalism; medical education, knowledge and specialist expertise confer status, authority and autonomy onto those qualified members of the profession. On the other hand, in contrast to the well established, highly organised and dominant medical profession, nursing has a different, more contested history characterised by a struggle to move beyond a semi-skilled vocational occupation towards professional status, nursing as a profession. The role relationships within health care are influenced by both the professional power and authority of medical doctors over nurses and the prevalence of managerialism which has brought new ways of working into health care practices; a result of which is that these role relationships are shifting with implications on role and identity formation.

3.3.1 Medicine and Management

The English NHS is a large professional bureaucracy (Currie & Procter, 2005) in which there is a "powerful professional cadre of core employees within the organisation – doctors" (ibid. p.1325). As previously described professionals maintain their status through social closure (Freidson, 2001); performance of actions and processes, for example, attainment of complex and extensive credentials, which protect the expertise and knowledge base of the professional group to the exclusion of others. In health care, the medical profession is the oligarchy (Mintzberg, 1979); doctors define and control the purpose, delivery and development of health services and have the power to resist and subvert any attempts to change the service which are perceived to be a threat to their professional autonomy; similarly, the profession co-operates if it serves their purpose to do so (Currie & Procter, 2005). This aligns with Quinn et al.'s (1996) assessment that professional elites are reluctant to support organisational objectives unless there is congruence with their own. McMurray (2010) makes the point that within the medical profession, there is an internal hierarchy between physicians, surgeons and general practitioners and between medical specialisms; the degree of influence varies according to which specialism and where in the hierarchy is being considered. Nonetheless, it is generally accepted that the medical profession dominates health care, with doctors situated "at the apex of the system" (Dent, 2003, p.5); a trend set to continue with recent pronouncements that General Medical Practitioners are preparing to take responsibility for the majority commissioning of health care services in England (BBC News, 5/4/11).

The medical profession is governed by the General Medical Council (GMC), and has been since 1858 (GMC website) illustrating its longevity as a professional body. It is the independent GMC that controls entrance to the profession through setting standards for medical training and education, determines and regulates medical work and supports good medical practice; by these terms, the medical profession is professionally autonomous (Dent, 2003). In addition, the British Medical Association (BMA) represents the professional and personal needs of medical doctors and has significant influence with government in negotiating and supporting "micro-level practices of autonomy, rights, power and control" (Harrison, 1999, p.51).

Whilst the discourse of managerialism has threatened professionalised occupations, the UK medical profession has retained its clinical autonomy, a result of "close corporatist relationships" (Harrison, 1999, p.51) between the profession and the formal organisation of the NHS in support of the medical profession and wielding "institutional power" (Dent & Burtney, 1996). Others argue that clinical autonomy has been retained by protectionism, ensuring power and autonomy stays within the profession rather than with managers; for example, the rise of the managerial doctor (medical director) as senior authority within the organisational hierarchy (Dopson, 2009; Harrison, 1999). Other professionals, for example, nurses and managers work within this medical hegemony; it is doctors that control the division of labour in health care (Dent, 2003; McMurray, 2010) thus exert power and influence on the inter-relations between themselves and other health care roles. To help in understanding the implications of medical dominance over nursing work, a historical overview of nursing as an occupation now follows.

3.3.2 Nursing as a Vocational Occupation

Hallam (2000) presents a detailed socio-historic account of the image of nursing in England; from the "dirty work" performed by women in the lowest social classes in caring for the sick and old to the 19th century Florence Nightingale era of nursing as a quasi-militaristic occupation with the introduction of nurse training as a class control mechanism, enhancing the status of nursing as a reputable occupational choice in order to increase recruitment from the middle classes; and onto the late 20th century professionalisation of nursing in the light of political, economic and cultural changes within the health service.

Throughout this, nursing emerges as "a profession dogged by insecurity, low status and gender inequality" (Ewens, 2003, p.227), where the prevailing public images of nurses are highly feminised and subordinated; 'handmaidens' in the predominantly male medical hierarchy; 'angels' of self sacrifice dedicated to the care of others. These images reflect a gendered occupation, understood in the light of social development of female identity (Öhlén & Segesten, 1998). McMurray (2010) argues that from a gendered

perspective, nursing is support work to "formal medical/male work" (ibid. p.6), of lower status and systematically undervalued.

There is support for the argument that nursing and nurses are invisible to policy makers because it is a feminised occupation situated within a strong, patriarchal structure of medicine (Crawford et al., 2008; Liaschenko & Peter, 2004; Taylor & Hawley, 2010). In their research on the impact of perceived public image of nursing on nurses themselves, Takase et al. (2006) comment on this invisibility, suggesting that a lack of understanding of nursing work leads to the public image of nursing as one-dimensional, a caring and feminine profession, undermining the complexity skills and capabilities required in nursing.

Kelly (1991, p.867) argues that student nurses "are groomed for subordination" the implication being that the traditional image of nursing is culturally embedded and unlikely to change. Fawcett (2003, p.229) agrees that "nursing is a culture that values or at least tolerates being oppressed." The "professional project" (Hallam, 2000, p.19) within nursing is thus documented as an attempt to redress these inequalities of power, low status and subordination of nursing within the medical hierarchy.

3.3.3 Nursing as a Professional Project

Hallam (2002) writes of the transition from 'vocation' to 'profession', where a growing criticism of the perception of nursing as a non-specialised and subordinated vocation prompted the move to professionalise the occupation through gaining educational qualifications at degree level and increasing technical proficiency and skills.

Freidson (2001) argues that credentialism, the attainment of specialised qualifications to attest to competence, is at the core of professionalisation. In 1972, the Briggs Report "encouraged the pursuit of nursing research and research-mindedness, and suggested that nursing should be a research-based profession" (Macleod-Clark et al. 1997, p.162) thus nursing began to become an academic discipline in its own right.

This emphasis on nurse education was strengthened further by the curriculum reform programme, Project 2000, proposed by the UKCC[1] to change the academic status of nursing, through the introduction of education to degree level, thus adding credentials to nursing practice and placing value on specialised nursing knowledge and expertise. In addition, continuing professional development is intended to enhance the process of professionalisation of nursing, regulated by the Nursing and Midwifery Council (NMC) and supported by the Royal College of Nursing (RCN). These are professional associations which provide leadership, accreditation and guidance on a professional code of conduct and by their very existence, add weight to the argument for nursing as a profession in its own right (Keogh, 1997).

Project 2000 encouraged a different type of nursing, a move away from the stereotypical image of 'doctor's handmaiden' to "a 'knowledgeable doer', with research based practice, and a sound rationale for the care given" (Macleod-Clark et al., 1997, p.166). In the shift to holistic patient centred care, nursing emerges as a profession underpinned by strong values and ethics of care, represented through personal commitment by individuals to the 'worthy cause' of nursing (Keogh, 1997).

One of the central aims of professionalisation is to achieve autonomy and self regulation as an occupational group, something which some argue is problematic within nursing because of the hegemonic medical hierarchy to which is it tightly bound (McMurray, 2010; Meulenbergs et al., 2004). Dent (2003) uses Weber's notion of professional heteronomy, i.e. subject to external authority in terms of its work and organisation, arguing that nursing aligns more to this concept whilst professionalisation is "a masculine project" (ibid. p.16) which reproduces patriarchal structures within society that serve to reinforce medical dominance. Meanwhile Salvage (1988) suggests that the professionalisation project in nursing was focused on gaining a degree of occupational control rather than achieving full autonomy in the traditional sociological sense.

[1] The UKCC (United Kingdom Central Council for Nursing, Midwifery, and Health Visiting) acted as the statutory body to regulate the nursing, midwifery, and health visiting professions in the UK. In 2002, the UKCC was superseded by the Nursing and Midwifery Council (NMC).

3.3.4 'Problems' of Professionalisation

Fagermoen (1997, p.435) writes that "professional identity [in nursing] is defined as the values and beliefs held by the nurse that guide his or her thinking, action and interaction with the patient." The core value appears as altruism, reflected in thoughts and actions that are ethical and moral, around issues such as dignity, respect and trust. Values, beliefs and attitudes are significantly important in defining nursing and what being a nurse means (White, 2002). Taylor (1997) identifies two strands in nursing; generalist 'hands on' care provision delivered by a majority of task-oriented nurses and specialist "new" nursing (ibid. p.443), founded on a belief in the 'science of caring' and seeking professional accountability and authority, arguing that both approaches to nursing are congruent and legitimised by a shared belief in patient centred care, underpinned by an ideology of altruism.

However, critics refer to contradictions within the conceptualisations of nursing as a caring vocation, a selfless calling of servitude to others and nursing as a profession imbued with unique knowledge and technical expertise and autonomy in practice, suggesting that professionalisation creates an elitist group of highly educated career focused nurses whilst undermining the vocational, caring aspects of nursing work (Hallam, 2000; O'Connor, 2008; Salvage, 2006). The implication is that by investing time and effort in training and education and by pursuing more specialist and strategic positions within the nursing profession, the nurse spends less time with the patient, thus acts "deviantly" and "threatens to damage the [patient centred] caring ethic" at the heart of holistic nursing care (Taylor & Hawley, 2010, p.157).

There is general agreement across the literature that professional role identity has to be consistent with the concept of self; that personal and professional identity are inextricably linked (Ewens, 2003; Fagermoen, 1997; Öhlén & Segesten, 1998; Sommerlad, 2007). Fagermoen (1997, p.439) makes the point that nursing is a human and moral practice which "maintains and enhances their self concept both as nurses and as humans" and it is through enactment of these core values of caring that an individual is able to bring meaning to themselves, a process of becoming (Hallam, 2000, p.28) and self-actualization. Öhlén & Segesten (1998 p.720) agree that it is at the level of the individual that professional identity is constructed; the extent to which an individual

embraces or rejects the vocational and professional aspects of nursing will vary according to each individuals' selfhood. O'Connor (2008) refers to the reflexive and emotional negotiation of the individual's own subjectivity whereby emotions inform and define professional identity construction, arguing that this is problematic when juxtaposed with technical rationalism of professionalism, as the emotional, value-laden aspects of caring become marginalized and rejected.

The professionalisation project has impacted directly on role and identity construction in nursing, encouraging more autonomous and specialised practice alongside maintaining fundamental, yet often contradictory, values of care; this conflict problematises the notion of a professional identity in nursing. To further complicate the problem, societal barriers such as patriarchal and class relations still exist to undermine nursing as inferior, feminised work (Taylor & Hawley, 2010), and are reinforced by the medical hegemony which dominates health care work; as Salvage (2006, p.260) states, "nurses are still ordered to care by societies that do not explicitly value or reward caring, or merely pay it lipservice." The professionalisation project has sought to gain autonomy from within the traditional medical hierarchy through the attainment of credibility and status acknowledging proficiency and capability through credentialism. However, whilst professional status has been enhanced through attainment of academic qualifications, the application of these credentials in practice is significantly restricted by the organisational hierarchy in which nursing sits (Crawford et al., 2008; McMurray, 2010). This serves to highlight the entrenched subordination of nursing within medicine.

Currie et al. (2010, p.942) present timely and relevant research located "at the crossroads of role transition, professional identity and public policy", analysing role transition within the nursing profession in the English NHS. They outline the context for the research as exemplifying public management practices globally "to reconfigure professional roles and relationships through skills mixing to engender more collaborative forms of health care delivery that are based on professional accomplishment rather than traditional jurisdiction, and so mediate shortages of doctors, curb rising costs, and improve quality of care" (Currie et al., 2010, p.942).

In other words, there is a challenge to the autonomy and knowledge domain of the medical profession as public policy moves towards cross boundary working, sharing

knowledge and broadening access to expertise beyond the professional group; for example, nurse prescribing extends the capabilities and competencies of nurses in a task that has been exclusively performed by doctors, immediately challenging the traditional doctor/nurse hierarchical structure as competence boundaries are delineated and "expertise" diffused across a wider group.

Currie et al. (2010) found tensions between collective and individual identity construction within a policy context of role transition, suggesting that the structural influences of the professional medical hierarchy are resistant to new roles that span boundaries and challenge the jurisdiction of medical knowledge and expertise; that institutional structural influences "counter any agency of those placed in the new, less bounded roles" (ibid. p.955). Others support this view, suggesting that whilst professionalisation aims to legitimise nursing through enhanced status, recognition and credibility, it has not delivered as organisational structures and hierarchies do not support either the role transitions required nor the fundamental principle of caring upon which nursing is built (Crawford et al., 2008; Ewens, 2003; McMurray, 2010).

3.3.5 Reconfiguring Professional Nursing Identity

Taylor and Hawley (2010) suggest in their précis of professionalism in health care that the traditional idea of professionalism, emphasising autonomy, expertise and elitism is too narrow and outdated in contemporary health care practice, with reform policies placing higher value on multi-disciplinary working and reflective practice, working across traditional boundaries and sharing knowledge as part of a "collective endeavour" to deliver patient-centred health care. Shifting the balance of power from solely medical authority to a broader range of health professionals, and particularly nurses, has led to a blurring of boundaries between medical treatment and nursing care and a reconfiguring of nursing roles.

The issues in defining professional nursing identity have salience with relational theories of identity (Sluss & Ashforth, 2007) where identity forms through the nature of the interaction between roles (for example, doctor – nurse) and identification is the extent to which the individual's concept of self is defined by the role. Role relationships,

interactions between individual and others define and construct professional identity and this has particular relevance to newly formed roles in nursing (Taylor & Hawley, 2010).

The tensions between traditional and new approaches to professionalism within nursing are increasingly apparent as individuals move from traditionally established to newly formed roles. With increasing complexity and ambiguity in role specification within nursing, the question arises as to how nurses individually and collectively reconcile the various tensions and conflicts between dualities of care/cure; vocation/profession; general/specialized nursing; professional/managerial which present in their roles.

The Modern Matron, a new nursing role, has been created through recent health care reform policy in the English NHS; it is intended as a position of nursing authority, working across professional, managerial and organisational boundaries in an endeavour to deliver patient-centred care (DH, 2003); the new nursing role can be regarded as an identity project, situated within multiple discourses of professionalism, managerialism and vocational care. The concept of Modern Matron is founded upon an historical legacy of a previous incarnation of the role, Matron, which adds complexity to role formation and raises the question, who is Modern Matron?

3.4 Matron: past, present and modern

When discussing the introduction of the Modern Matron role into the contemporary NHS, it is important to note an earlier incarnation of this role which dominated the nurse hierarchy in pre and post war years and still resounds in people's memories today.

Historically, Matron held a senior role in the nursing hierarchy, with authority and quasi-militaristic control over junior nurses on the wards. Working alongside the hospital administrator and physician, the Matron belonged to a tripartite hospital management team, and was the most senior nurse within the hospital (Hallam, 2002). Bufton (2005, p.1186) describes how "the image of Matron symbolised order, tradition and controlling leadership." Matron was a domineering "battleaxe" responsible for ensuring the smooth running of the ward, assuring high standards of cleanliness, keeping wards tidy and ensuring patients were properly fed and looked after (Stephens, 2002).

This traditional role of Matron ceased to exist after the Salmon Report (1967) recommended changes to the senior nursing staff structure within the NHS, raising the profile of nursing as a profession within hospital management. Subsequent reforms to nurse training and education supported the agenda to professionalise nursing during the 1970s and 1980s, and led to a transition from nursing as a non-specialised and subordinated 'vocation' to nursing as a highly trained, technically proficient and managerially capable 'profession' as reflected in the emergence of new nurse manager roles (Hallam, 2002). Contemporary nursing practice and its professional and managerial hierarchy is significantly different; old Matron's authority would not fit with nursing today (Currie et al., 2009). It has been argued that the abolition of the Matron role removed authority and control from those running the wards concurrent with policy reductions in cleaning budgets (Day, 2005) and that these changes have led to a decline in standards of cleanliness and hygiene on the wards.

3.4.1 Reform Policy: "Bring Back Matron"

In recent years, declining standards of cleanliness and hygiene on hospital wards and rising patient deaths due to hospital acquired infections has led to increasing public concern about nursing standards. At the time of conducting this research there was heightened public concern regarding a high number of deaths from Methicillin-resistant Staphylococcus aureus (MRSA) in the UK[2], an issue that gained momentum in the media in the run up to the General Election in May 2005 with rising concern about declining standards of cleanliness in hospitals and blame levelled at government for financial cuts and contracting out of cleaning services. The introduction of the Modern Matron role to take a lead on managing infection control and quality of care is an attempt by Government to respond to this discontent (Day, 2005; Koteyko & Nerlich, 2008).

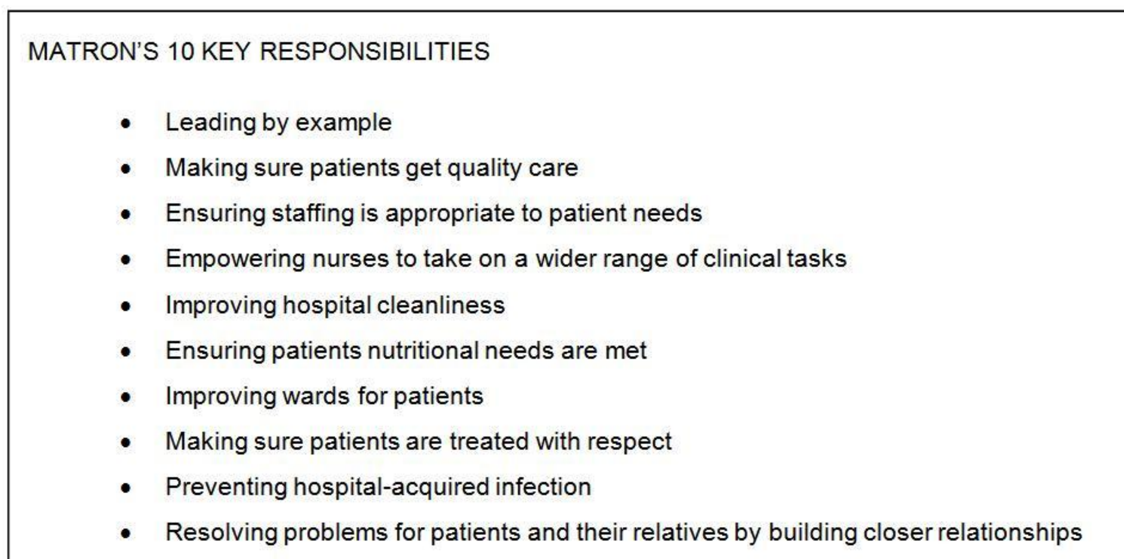
This is a purposively constructed senior nurse role (DH, 2003; Smith, 2008a & 2008b) intended "to provide a clear focus for clinical leadership across a group of wards and a highly visible, accessible and authoritative figure upon whom patients can rely to ensure

[2] The Office of National Statistics reported 1,629 MRSA-related deaths in England and Wales during 2005 (http://www.statistics.gov.uk/cci/nugget.asp?id=1067 date accessed 15-02-11).

that the fundamentals of care are right" (DH, 2001b, p.6); the policy rhetoric of Matron as the guardian of basic nursing standards is evident, as Washer and Joffe (2006, p.2148) explain, "the saviour of this situation …it is imagined that such a figure would resolve the hygiene problems, and thereby allay the spread of MRSA."

In policy terms, the Modern Matron role has three core aims: to provide leadership to clinical staff; to ensure availability of administrative and support services and to be visible to patients and their families. Policy guidance on what is expected of the Modern Matron role is provided in the form of ten key responsibilities (Figure 3.1),

Figure 3.1: Matron's 10 Key Responsibilities



MATRON'S 10 KEY RESPONSIBILITIES

- Leading by example
- Making sure patients get quality care
- Ensuring staffing is appropriate to patient needs
- Empowering nurses to take on a wider range of clinical tasks
- Improving hospital cleanliness
- Ensuring patients nutritional needs are met
- Improving wards for patients
- Making sure patients are treated with respect
- Preventing hospital-acquired infection
- Resolving problems for patients and their relatives by building closer relationships

(DH, 2003, p.5)

The policy documentation makes explicit the accountability within the Modern Matron role for clinical governance issues. Within the policy discourse is an assumption that the Modern Matron role is positioned at an appropriate level within the organisation to lead quality assurance in clinical practice on key issues such as infection control and quality in patient care whilst also managing resources and enabling a positive patient experience (DH, 2003; DH, 2001b). This requires strong leadership with recognisable authority

which spans all aspects of the organisation, within and beyond structural and organisational boundaries and across clinical and non-clinical domains, a hybrid and cross-bounded position spanning the professional (nurse) and managerial boundaries to deliver better quality care within a politically driven environment of change and reform (Ainsworth et al., 2009; Bolton, 2003; Forbes & Hallier, 2006; Savage & Scott, 2004; Sveningsson & Alvesson, 2003; Whitchurch, 2008).

The policy remit presents significant challenges in relation to working within an established professional hierarchy and mediating between professional and managerial boundaries (Currie et al., 2009). Recent literature highlights the complex and contested arena into which the Modern Matron role has been introduced. The Modern Matron is a "politically high profile role" (Dealey et al., 2007, p.23) constructed by Government in response to public demands for greater accountability and visible authority on the wards (Bufton, 2005). The decision to "bring back Matron" has led commentators to express "widespread dismay" at what they regard as "populist" and "muddled thinking" by the state, arguing that the implicit assumption that Matron is 'the silver bullet' (Mooney, 2008) in tackling basic nursing issues of cleanliness and infection is unwise, particularly as the traditional image of Matron is at odds with contemporary nursing practice (Elliot, 2003; Snell, 2001; Stephens, 2002). Currie et al. (2009) argue it is a nostalgic attempt by policy makers to reintroduce an idealised perception of a "golden age" of health care "where Matron was a figure of authority over others" symbolising "order, tradition and a controlling style of management" (ibid. p.297).

There is considerable argument that the traditional Matron role is outdated for nursing practice today, where the professionalisation of nursing, emphasis on empowerment and transformational leadership contradicts the didactic authoritarianism encapsulated by the old style Matron (Bufton, 2005; Currie et al, 2009; Hallam, 2002; Snell, 2001; Stephens, 2002). Currie et al. (2009, p.299) observe that,

> Professional and managerial hierarchy and practice no longer resemble the system within which the old style Matron was able to exercise authoritative power. Within the shifting terrain of nursing, which encompasses professionalisation, changing nurse roles, continued subordination to doctors and marginalization within managerial decision-making, enactment of the Modern Matron role, with the authority that characterized previous incarnations of the role, may prove challenging.

This reflects similar observations from other empirical studies on the reinstatement of the Modern Matron into the NHS (for example, Ashman et al., 2006; Dealey et al., 2007; Gould, 2008; Smith, 2008a & 2008b). These studies share similar findings with regard to the challenges and issues arising from the implementation of the new role including the extent to which the role was essentially managerial, essentially clinical or a mixture of both (Read et al., 2004) and the conflicting priorities between these domains; the importance and challenges of maintaining visibility as a publicly recognised figure on the ward; earning and maintaining credibility with colleagues and staff and finally, distancing themselves from the historical image of Matron. Read et al. (2004, p.10) summarise,

> The role is complex and (as the guidance documents recognise) the effectiveness of Matrons will depend considerably on the extent of their authority, the resources they can command, and the nature of the working relationships they establish with ward nursing staff, other clinical practitioners and service managers across the organisation.

The literature on Modern Matrons tends towards descriptive evaluations of the implementation of the role in practical terms rather than theoretical critiques of the role, indicating a gap in the literature to which my research can contribute. One paper which does offer theoretical critique is that of Currie et al. (2009) who argue that the introduction of the Modern Matron role as a hybrid managerial role to resolve infection control issues is problematic.

Their findings from qualitative research with Modern Matrons and nurses in an NHS Trust suggest that whilst policy presents the Modern Matron as “enjoying authoritative freedom liberated from bureaucratic constraint” (ibid. p.296) in practice this authority is diminished. The role has been introduced into an existing professional hierarchy of medical dominance where nurses have little influence over medical staff; the positioning of the Modern Matrons in the organisation, to work alongside rather than above other nurses resulted in “few health care staff believing themselves to be accountable to the Modern Matron” (ibid. p.305). The managerial aspect of the role, to monitor and audit quality of health care provision resulted in mainstream nursing staff protecting “their jurisdiction over quality of health care” (ibid. p.308) and, through their lack of cooperation further reducing the Modern Matrons’ domain of influence. In addition, Currie et al. (2009) suggest that the Modern Matron role “sits awkwardly with contemporary changes in the nursing profession” (ibid. p. 298) as it focuses on mundane aspects of hands on nursing care, in effect “dumbing down” the technical and specialist skills of professional nurses, thus undermining the professional project. A further point they make is that policy is inconsistent, without budgetary responsibility or control over subcontracted services (e.g. cleaning); the impact of the Modern Matron role on addressing infection control issues is limited.

In summary, the research conducted by Currie et al. (2009) found that whilst other health care professionals (medics, nurses) agreed in principle to the Modern Matron remit on infection control, they did not respond to the managerial leadership in this area; the Modern Matrons only seemed effective when “infection control activity was situated in professional practice” (ibid. p.309). These research findings have particular resonance with my exploration of the Modern Matron role. They raise important observations about the role dynamics at play when situating the new role within an existing professional hierarchy; highlight the challenge within the role, mediating between managerial and professional values and demonstrate inconsistencies between macro-level policy and micro-level practice.

3.5 Concluding Thoughts

A review of the literature has shown identity to be a useful analytic frame in organisation studies which helps to understand the complex, dynamic relationship between self, work and organisation (Alvesson et al., 2008); individuals interact with others in the social environment and by doing so, create multiple, discursively constructed identities. One such identity arising from the workplace is professional identity, a facet of self and identity, and performed through enactment of roles and relationships (Hotho, 2008; Macdonald, 2006).

Medicine is an example of the archetypal, traditional profession where credentials, expertise and knowledge confer professional status, power and authority onto members of the profession, doctors (Freidson, 2001; Hughes, 1963). By comparison, nursing is an occupation with an historical legacy of subordination within the medical hierarchy; a feminised, vocational pursuit of caring that serves to support the formal, masculinised profession of medicine (Ewens, 2003; McMurray, 2010; Öhlén & Segesten, 1998). In more recent times, nursing has undergone a professionalisation project (Hallam, 2000), challenging the gendered subordination of the occupation and raising the status of nurses through credentialising their technical knowledge and expertise although research suggests that despite achieving professional status in their own right, nursing practice continues to be constrained within the dominant field of medicine (Currie et al., 2010; McMurray, 2010).

As nurses struggle to attain occupational professionalism (Evetts, 2005), professionalism itself is under threat from a new managerial discourse of efficiency and reform (Dopson, 2009; Exworthy & Halford, 1999; Ferlie et al., 1996). New public management has sought to shift power and authority from professionals to managers with inevitable tension and conflict. Professionals now manage and are managed; managers seek to be 'professional' in their conduct and demeanour, a new form of hybrid management is appearing (Ainsworth et al., 2009; Sveningsson & Alvesson, 2003). Emerging from this is a new type of professionalism, where professionals learn to be effective managers as they attempt to regain control over their work; a process of reconfiguring role and identity (Dent & Whitehead, 2002; Meulenbergs et al., 2004; Paulson, 2006).

What can be surmised is that professional identity in nursing is multiple and complex with conflicting tensions within the professional hierarchy, between medicine and nursing and across competing discourses of professionalism, care and managerialism. What is of interest to my research proposition is how the individual mediates and reconciles these tensions, drawing from self and other, to establish and constitute their role and identity (Alvesson et al., 2008).

An example of a new hybrid management role in health care is the Modern Matron, introduced into the nursing hierarchy in the English NHS, as part of a reform objective to improve standards in quality of health care in nursing. Within the research that has been conducted into the Modern Matron role, there is the suggestion that it is problematic in relation to issues of working within a professional hierarchy; role dynamics between the Modern Matron and other health care staff; tensions between professional leadership and managerial control; competing discourses of professional nursing and holistic nursing care; and inconsistencies between macro level policy and implementation at the local level (Ashman et al., 2006; Currie et al., 2009; Read et al., 2004).

My research considers the Modern Matron role as an identity project, drawing from identity literature to consider how role dynamics and competing discourses constitute the role as performed in an English NHS Trust. The following chapter presents methodological considerations when conducting qualitative research and the methodological choices which have guided this research.

4 METHODOLOGY

My primary research interest is to listen to the voices of Modern Matrons as they talk, in their own words about themselves and their work in order to gain insight and understanding on what it means to be a Modern Matron in the English NHS. Qualitative research offers methodological choices for researchers wishing to explore human experiences in social settings. Therefore, this chapter offers an overview of qualitative research, its origins, key features and considerations to be made with a view to identifying the relevance of qualitative method to my own research.

4.1 The Research Area

Research literature highlights an epistemological continuum between positivism - the objective search for scientifically proven truth, testing theory through deductive reasoning against a preordained hypothesis, and; phenomenology - a subjective and interpretive approach to exploring social phenomena, building theory through inductive analysis of the data. Naturalistic, qualitative inquiry focuses on the context and meaning of social interactions, behaviours and events (Crotty, 2003; Denzin & Lincoln, 2005; Saunders et al., 2000).

Qualitative research has a long-standing history across many disciplines including sociology where the Chicago School of American sociologists "established the importance of qualitative inquiry for the study of human group life" (Denzin & Lincoln, 2005, p.1) developing philosophical approaches to understanding the social world such as interpretivism, social constructivism and symbolic interactionism (Hatch & Cunliffe, 2006; Lofland et al., 2006). Similarly, anthropologists such as Boas, Mead and Malinowski established methodological approaches to conducting fieldwork, a process of observing and gathering data from different societal and cultural settings. From these beginnings, qualitative research has become prevalent as a means of social inquiry across many disciplines including management and health (Denzin & Lincoln, 2005). Pope et al. (2002, p.148) describe qualitative research as,

> The systematic collection, organisation and analysis of textual material derived from talk or observation. It is rooted in the interpretive perspectives found in the humanities and social sciences that emphasise the importance of understanding, from the viewpoint of the people involved, how individuals and groups interpret, experience and make sense of social phenomena.

Whilst Denzin and Lincoln (2005, p.8) describe it as,

> The socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry.

Implicit within this is the subjectivity of the researcher as part of the social process that is being observed hence qualitative research is "value-laden" (ibid. p.8) requiring a degree of reflexivity from the researcher as to the implicit subjectivities they bring to bear on research design, implementation and analysis (Denscombe, 2007).

Burrell and Morgan (1979) refer to research philosophy as either objectivist or subjectivist, suggesting that these are mutually exclusive, hence a choice has to be made as to which to follow and, by doing so, commit to a series of assumptions about the social world whilst rejecting others. Latterly, this standpoint has faced criticism by those favouring paradigmatic pluralism (Wilmott, 1993) with recent literature presenting the polarised positions on a continuum, emphasising a more pluralistic view for multi-method research (Brannen, 2005; Crotty, 2003; Hatch & Cunliffe, 2006).

Denzin and Lincoln (2005) use the metaphor of "bricolage" to explain the ways in which the researcher may "invent, or piece together, new tools or techniques' (ibid. p.4), crossing either or both theoretical and methodological boundaries to emerge new perspectives, theorizations and findings. This enables the researcher to explore data freely and inventively but poses the challenge of being able to show rigour and consistency of approach, particularly when conceptualizing theory (Bryman & Burgess,

1994; Denzin & Lincoln, 2005). These concerns can be addressed in the approaches taken to data analysis, which is discussed later in this chapter (Section 4.4, p.80).

4.2 Doing Qualitative Research

It is generally acknowledged within the literature that social research, by its very nature, is unique and dynamic, and that the qualitative researcher will draw on several methodologies when conducting research (Bryman & Burgess, 1994; Crotty, 2003; Denzin & Lincoln, 2005). The qualitative research landscape is vast, encompassing innumerable approaches and methods, aligned with different interpretive paradigms (for example, constructivism or critical theory). Transcending these it seems are fundamental elements that describe the research process.

Denzin and Lincoln (2005) suggest five aspects of the research process which involve identifying: the researcher as subject; the theoretical paradigm; the research strategy; methods of data collection and analysis; and interpreting and presenting findings. Crotty (2003) presents four interconnecting elements to describe the process: epistemology; theoretical perspective; methodology and methods. Meanwhile Lofland et al. (2006) refer to three cornerstones of interconnected tasks: gathering data through a choice of methods; focusing data in terms of theoretical concepts and analysing data using approaches relevant to the area of study.

The challenge for the researcher is to locate oneself within a theoretical paradigm (e.g. positivist, interpretivist, critical theorist) and make choices about which research strategy (e.g. case study, ethnography, action research) and data collection methods (e.g. interviews, observation, questionnaire) to employ. Bryman and Burgess (1995, p.217) suggest that "research design, data collection and analysis are simultaneous and continuous processes." Whilst there is a "general order" (Lofland et al., 2006, p.1) guiding these choices (for example, Crotty's methodological categories, Appendix B) research is not a linear process, the doing of research is dynamic, with flow "in all directions" (Crotty, 2003, p.12) both in choice of method and actions taken. The concept of "bricolage" has relevance here; King (2004, p.269) comments that there are "no absolute rules" with regard to how to approach qualitative data analysis and that the

researcher has to navigate through a myriad of options and choose an approach that suits both the research topic and epistemological position taken, a point echoed by others writing on qualitative research methodology (Crotty 2003; Denscombe, 2007; Eaves, 2001). With this in mind, I turn now to the methodological considerations for this research.

4.3 Methodological Considerations for this Research

As identified in the literature review, this research focuses on the construction of professional identity within a health care organisation setting. It borrows from organisation theory which seeks to understand the dynamics of human interaction embracing complexity, diversity, unpredictability and pluralism within the social world and interpreting these through an analysis of organising and organisation (Hatch & Cunliffe, 2006). Qualitative research offers a myriad of ways by which to explore the contextual and contingent aspects of social life and organisation.

My primary interest is to gain insight into the thoughts, feelings and opinions of the research participants as they talk about themselves, their role and their work. A qualitative approach is required to elicit this highly contextual, experiential and value-laden data. I am not bound to one theoretical paradigm; this research sits across an interpretive paradigm of social constructivism, founded on the belief that self, identity and social reality are constructed through interaction between individuals and groups whilst also considering from a more critical perspective how social interactions are in turn constructed through language, discourse and relations of power. Both perspectives offer useful theoretical insights for interpreting the data.

4.3.1 Qualitative Research in Health Care

Health care research has a long-standing association with the positivist paradigm, particularly within "clinical and biomedical research" (Pope et al., 2002, p.148) where research practice, for example, randomised controlled trials, is based upon the analysis of hard, quantitative and objective data. However, qualitative research in health care also

has value in exploring health care as a complex social system, enabling contextual studies of human interaction which constitute the organisation (Barbour, 2001; Pope et al., 2002).

There are innumerable examples of qualitative research within health care across the literature. In relation to this research, studies considering identity in nursing and more specifically, those exploring the Modern Matron role tend towards ethnographic and longitudinal case study research or action research, employing methods such as interviews, observation and document analysis and analysed with use of thematic coding and/or discourse analytic techniques (for examples, see Appendix C). It seems appropriate to consider these commonly used research strategies and methods in relation to the methodological choice I have made.

4.3.2 Research Strategies

The research strategy describes the methodological approach taken to the research and accounts for the choice of methods used in data collection (Crotty, 2003). Ethnography, Action Research and Case Study are three methodologies which support qualitative exploration of social phenomena (Denzin & Lincoln, 2005).

4.3.2.1 Ethnography

Ethnography is a research strategy which aims to uncover meanings and perceptions of people within a given social setting through direct involvement and participation by the researcher in social setting. It has historical roots in anthropological fieldwork where the researcher lives within the society under study. It is argued that ethnography offers the best approach to gaining insight into everyday 'lived experience' (Brewer, 2004; Tedlock, 2000). For the researcher, full participation in the research field requires reflexivity in evaluating findings and being aware of self in the research process (Denscombe, 2007). Ethnography has broad application across disciplines and research settings as it offers a useful methodology for firsthand interaction with research subjects in their everyday lives (Tedlock, 2000).

An ethnographic approach to this research would have enabled me to gain in-depth understanding of the 'lived experience' of the Modern Matrons. However, there were constraints placed upon access in the ethics approval process that meant an ethnographic approach would have been impractical in light of the intensive participation on site that would have been required.

4.3.2.2 Action Research

Action Research is a practitioner based approach to improving and changing "real world" practice on the basis of evaluative evidence from research. Kurt Lewin is ascribed as the founder of action research (Denscombe, 2007), promoting it as a practical and applied approach to social change. It operates through an ongoing feedback loop of researching to evaluate practice and then using the knowledge generated from research to inform and change future practice; action leads to research which leads to action. Action research democratizes the relationship between practitioner and researcher as it requires mutual collaboration and shared knowledge; it has been used in a wide range of settings, most notably social research (e.g. community based projects) and education (Kemmis & McTaggart, 2000). However, it has been criticised for poor design, lack of rigour and for failing to achieve expected outcomes, particularly in the health care setting (Bate & Robert, 2002).

At the time of designing my PhD research, I was involved with an action research project. It would have been feasible to build upon my relationship with the Trust (see Section 5.3.1, p.98), and suggest an action research project around Essence of Care benchmarking, but given my firsthand experience of this approach, I did not feel it was the methodology I wanted to apply to this research. It would have placed limits on the scope and scale of my research interests as I would have been beholden to the Trust's aims and objectives (Denscombe, 2007).

4.3.2.3 Case Study Research

Case study research is highly prevalent across the social sciences, including organisation studies (Hartley, 2004). The advantage for qualitative researchers is that the case study facilitates an in-depth, detailed investigation of phenomena within a specified social

context. Yin (1994, p.1) suggests that case study approach is useful when asking "when, how and/or why questions; when the researcher has little control over events; when the focus is on a contemporary phenomenon within a real-life context." Case studies look at the particular within a natural setting using inductive analysis to understand the social context (Hartley, 2004).

There is variation within the case study approach dependent on the aims of the research; whether it is a comparative study of multiple sites or an exploration of a single site; whether it is to discover or explain events, processes and social interactions and whether the findings can be generalised or used to test theory (Denscombe, 2007). Miles and Huberman (1994, p.25) refer to a case "as a phenomenon of some sort occurring in a bounded context" and that fundamentally, a case is a unit of analysis, of which there may be one or many. Within the literature, there is criticism of the lack of generalisable outcomes from case study research, particularly in relation to single site case studies (Denscombe, 2007; Yin, 1994). Piekkari et al. (2009) differentiate between positivistic and interpretive case studies, suggesting that Yin takes a qualitative positivist perspective with a focus on achieving generalisable outcomes. Meanwhile Stake (2000) offers a interpretive perspective (Piekkari et al., 2009) arguing for "intrinsic" case studies, where the nature of the inquiry is focused on "understanding what is important about that case within its own world" (Stake, 2000, p.439) and as such is not concerned with representation or generalisation; rather the case is "undertaken because, first and last, the researcher wants a better understanding of this particular case" (ibid. p.437).

Hodkinson and Hodkinson (2001) observe that whilst case study research can offer in-depth knowledge of social context and behaviour, there are limitations associated with the volume and complexity of data that is gathered. During analysis, the researcher constantly makes subjective judgements over the significance of the data and actively chooses which data to use in analysis; the risk being that data can be taken out of context or over simplified for the purposes of analysis. Hodkinson and Hodkinson (2001) suggest that transparency of the data analysis process and trust in both the researcher's judgement and their personal motivation to represent the data as "truthfully" (Lofland et al., 2006) as possible, are ways by which to address these criticisms. Whilst a single case study may not produce generalisable outputs, it may "ring true" with other similar

research and offer new thinking in relation to the broader field of study (Hodkinson & Hodkinson, 2001).

I find Stake's definition of intrinsic case research to be particularly useful in confirming this as a credible methodological choice that has salience with my research. It enables focus in detail on a particular phenomenon within a defined organisational context which aligns with my research aims to gain in-depth understanding of the Modern Matron role as it is performed within a single NHS Trust.

4.3.3 Research Methods

Qualitative research approaches enable the use multiple methods of data collection, including interviews, observation and document analysis; all of which are prevalent in social research (Crotty, 2003).

4.3.3.1 Interviews

Given its widespread use as illustrated in the literature (Appendix C), it can be expected that I would consider interviews as a primary method of data collection. Interviewing is an effective method for gaining insight from individuals, particularly with regard to feelings, emotions, experiences and opinions (Denscombe, 2007). There are different types of interview to be applied in a range of settings, dependent upon the purpose of data gathering, whether to explore "what" or explain "how" and "why." Structured interviews tend to follow a highly standardised questionnaire based format which can be advantageous when conducted to verify *a priori* assumptions; in this case the interviewee responds to the researcher's questions with little or no diversion from topic. At the other extreme, the unstructured, or in-depth interview, tends to be a deliberately undirected conversation between respondent and researcher, where the research topics are described by and emerge from the respondent.

In a semi-structured interview, the researcher guides and steers a dialogue between researcher and respondent using a number of pertinent themes or topics as prompts. There is flexibility in the order in which the themes are approached dependent on how

much the respondent takes the lead themselves (Saunders et al., 2000). Both unstructured and semi-structured interviews rely upon the skill and competencies of the interviewer to ask open questions, probe for further depth, pause for reflection and enable respondents "to use their own words and develop their own thoughts" (Denscombe, 2007, p.176).

King (2004, p.21) suggests that interviews are the most commonly used method of gathering qualitative data and that,

> One area where qualitative interviews may be of great use is in studying organisational and group identities in large organisations, such as the NHS, where a complex pattern of organisational, work group, professional and interpersonal loyalties exist.

In view of this, interviews would appear to be an appropriate choice as a method of data collection for this research.

4.3.3.2 Observation

Angrosino & Mays de Perez (2000) comment that at the most basic level, all social scientists "observe" in social settings; observation enables the social researcher to gain firsthand experience of the research site, engaging directly with the research subjects in the field to achieve "authentic insight" (Waddington, 2004, p.163) into social behaviour. It offers an inductive way by which to frame the research as observations can inform further data collection and analysis of in-depth rich, descriptive data. Participant observation derives from sociological and anthropological practice and can be covert, where the identity of the researcher is unknown to the subjects being studied, or, perhaps more commonly, overt where the researcher's identity and purpose is known to the research subjects. The extent to which the researcher "participates" in the research setting varies, dependent upon the nature and purpose of the research and also upon the access permitted by those being researched, and by other interested parties, for example, an ethics committee (Angrosino & Mays de Perez, 2000). Ethnographic studies tend towards complete participation or participant-as-observer whereby the researcher enters

the field of study, forms relationships with research subjects and actively participates in daily activities; this type of observation is guided by codes of conduct and ethical practice in relation to the extent to which the researcher involves themselves with events, activities and relationships pertaining to the research setting (Angrosino & Mays de Perez, 2000; Waddington, 2004). A central concern with participant observation is the subjective inter-relations between researcher and those being researched; it is a fluid and dynamic dialogue of changing identities and power relations which are negotiated and managed throughout the duration of the research (Angrosino & Mays de Perez, 2000).

Observation also includes 'observer as participant' where there is superficial contact between the researcher and those researched and 'complete observer' where the researcher does not participate, instead "eavesdrops" on situations, events and happenings (Saunders et al, 2000; Waddington, 2004). These approaches require less intensive involvement by the researcher and yet still enable insight into the social world being studied; in my case, my observation was limited to attendance of organisational meetings at which I was an "observer as participant" (Saunders et al., 2000); I was involved as a guest speaker and also as a spectator taking notes but I did not directly participate in the 'business' of the meetings.

4.3.3.3 Documentary Data

Documents and artefacts are a different source of factual and historical data, occurring in various forms, written and non-written (Hodder, 2000). Rowlinson (2004) observes that organisational researchers tend to use documentation as secondary source data to supplement primary data, often giving background information and context to the research setting. There are many forms of documentation: formal, official documents include licenses, contracts, government reports and public records; and unofficial, personalised documents, typically in the form of diaries, letters and memos. Other more contemporary forms of documentation include internet pages and alternative media such as photographs, digital images and videos (Saunders et al., 2000). Documentation is regarded as relatively easy to access (Denscombe, 2007; Hodder, 2000; Saunders et al., 2000) although there are some considerations to be made in documentary analysis with

regard to authenticity of the document; credibility of the source; representativeness of the data and meaning ascribed to it (Denscombe, 2007). Reading documents is an interpretive act (Hodder, 2000) within which the subjectivities of both the author and the reader are at play, a point to be cognizant of when analysing documents as data.

Secondary data that I have referred to in the course of this research is publicly available written material in the form of Government policy documents and the Trust's own documentation, such as the Annual Report and the Trust website. The purpose of referring to documentation has been, as suggested by Rowlinson (2004) to give background, historic information which has helped to contextualise the research. I also refer to personal notes and memos written as and when ideas, thoughts and reflections occurred to me during the research process (Corbin & Strauss, 2008).

4.4 Analysing Qualitative Data

Criticisms levelled at qualitative research in health care research (Malterud, 2001; Mays and Pope, 1995) focus on the particularity, partiality and lack of reproducibility in qualitative methods. In other words, the innate subjectivity of the researcher as an actor in the research process; the tendency toward in-depth study of one or two cases rather than generalising from many; and the fact that the research process is unique and personal such that another researcher may attempt the same process but reach different conclusions, has been considered problematic.

However, whereas quantitative data analysis can be a discrete part of the research process, Glaser and Strauss (1965) refer to the "continual blurring and intertwining" (ibid. p.6) of data collection, implicit coding and data analysis. Bryman & Burgess (1995) argue that the nature of qualitative data, its bulk and complexity, "voluminous, unstructured and unwieldy" (ibid. p.216) and the way in which data emerges through iterative, interwoven processes mean that qualitative data does not naturally lend itself to the routinised analytic procedures common to quantitative research methods.

Gibbs (2002) suggests that there are three approaches to qualitative analysis: *structured analysis* such as pattern matching and testing of causal links between data; *grounded*

theory, an in-depth, iterative process of coding, conceptualizing and theorizing from data; *discourse analysis: including narrative, life history and biography*, focusing on language use, textual data and stories as analytical tools for qualitative data and particularly useful for structuring ideas of self and establishing identity. Of these three approaches, it is suggested that the more predominant methodologies used within qualitative social research analysis are Discourse Analysis and Grounded Theory (Bryman & Burgess, 1995; Dew, 2007).

4.4.1 Discourse Analysis as Method

Discourse Analysis, a multidisciplinary approach, provides a way by which to explore, through language and narrative, individuals and groups as they interact to construct a particular social world (Grant et al., 2004). As has been identified in the literature review (Section 2.7, p.44), Discourse Analysis is a recognised methodological approach in social science research for eliciting and inducing theory from textual data, both written and spoken. It enables in-depth analysis of social practice through text and talk (Länsisalmi et al., 2004) and is therefore particularly salient for phenomenological, interactionist and constructivist research.

There are various ways by which to analyse text and talk across a range of techniques which scrutinize speech conventions such as turn taking and grammatical structure; conversation analysis is one such example (Samra-Fredericks, 2004). Harding (2008) uses a socio-linguistic analysis of personal pronouns, gaps and interruptions in speech to demonstrate how individuals explore self in the process of identity construction. Smith (2000) reviews the use of content analysis and narrative analysis as techniques for systematically identifying specific linguistic structures in spoken text to elicit understanding of an individual's construction of their lived experience. In depth linguistic analysis of use of words, grammar, and language has relevance to understanding text-in-use (Alvesson & Karreman, 2000) at a micro-level.

After initially considering a discourse analytic method of analysis, I decided against taking a 'text-in-use' approach which involves in-depth scrutiny of text, for example, quantitatively counting words and scrutinizing grammatical occurrences on the basis that

the relevance of discourse to this research is as theory rather than method. Instead, I refer to discourse in the Foucauldian sense as a meta-narrative, working at the ideational/ideological macro-level of social processes (Fairclough, 1992; Sveningsson & Alvesson, 2003) and acting "as a powerful ordering force in organisations" (Alvesson & Karreman, 2000, p.1127); in these terms, my mode of engagement with discourse (Grant et al., 2004) is with regard to the analysis of organisational phenomena, using discourse as an analytic lens.

4.4.2 Understanding Grounded Theory

Grounded Theory, deriving from the discipline of sociology and within the philosophical paradigm of symbolic interactionism (Eaves, 2001) enables an inductive approach to understanding social processes within the context that they occur, discovering theory from data through processes of coding, categorization, conceptualization and theoretical reflection.

Glaser and Strauss (1965, 1967) developed Grounded Theory as a way by which to induce and generate theory from empirical data, hence being informed by the highly contextual and specific lived experience. This shift in emphasis from deductive reasoning deliberately challenged the normative approaches in sociological research which relied heavily upon deductive, quantitative analysis and logical theory testing. Grounded Theory offered a new approach, a "style of conducting qualitative data analysis…providing new insights into the understanding of social processes emerging from the context in which they occur" (Länsisalmi et al., 2004, p.242).

This methodological approach fits well with research aiming to explore particular social phenomena as it focuses on uncovering social phenomena and processes as they occur and conceptualizing from this. Grounded Theory provides an analytical framework for gathering, coding and theorizing from qualitative data aiming for density and saturation of themes through constant comparison of codes and concepts for similarities and relationships between the data (Bryman & Burgess, 1995; Gibbs, 2002; Länsisalmi et al., 2004). There are three levels of coding: open; axial; and selective describing an

iterative process from initial coding to in-depth focused theorizing on a small number of salient concepts.

Initially, open coding will reflect a number of general themes and overall ideas that emerge from the data, *in-vivo,* often with sub-codes reflecting multiple perspectives on the overall theme and operating at different levels or dimensions across the data set, for example individual, group or organisation-wide. During this phase, the researcher may use a range of analytic techniques when generating the codes, such as ‘flip-flop’ looking at extremes in data; ‘red flags’ signaling expected/unexpected, visible/hidden, included/omitted data; and key word analysis, listing all possible meanings of words used. In conjunction with coding, memos capturing ideas, thoughts and reflections are a significant adjunct to the researcher’s analytic arsenal (Corbin & Strauss, 2008).

Axial coding follows the initial open coding phase, enabling the researcher to explore the relationships between codes and sub codes, in relation and with reference to context, action and causal conditions. From this, selective coding of one or two key themes emerging as central to the research and around which the research thesis can be induced, will occur. The analytic process of identifying concepts and relationships within and between coded data is fundamental to Grounded Theory technique.

Alongside coding, the researcher should write theoretical memos, which help inform theory generation. Generating theory is an iterative process of coding, analysis and further coding until a point of “saturation” (Corbin & Strauss, 2008, p.146) is reached. This process is ‘theoretical sampling’ (ibid. p.143). When a code “offers considerable depth and breadth of understanding about a phenomenon” (ibid. p.149) the process can be drawn to a conclusion.

Grounded Theory is a protracted, rigorous and detailed analytical approach to qualitative data and has become a leading method in qualitative research, and often used in health and nursing research (Eaves, 2001). However, whilst many purport to having used Grounded Theory technique in research, there is a growing criticism over how many

researchers use the approach in the way Glaser and Strauss originally intended (Bryman & Burgess, 1995; Denscombe, 2007; Eaves, 2001; Wilson & Hutchinson, 1996).

Critics argue that there is a rise in research using Grounded Theory but that this is often conducted with "a lack of adherence to the method as explicated by its originators, Glaser and Strauss" (Eaves, 2001, p.654). Eaves (2001) presents a useful overview of the continuing debate between theorists as to when research has and has not adhered to the fundamental principles of Grounded Theory. She argues that qualitative researchers need to be explicit and open about the methods and approaches they use, offering transparency on how they have understood and interpreted their data in order to confirm and validate their findings, whilst recognizing that by the very nature of interpretive, qualitative research, "every researcher [who uses the GT method] will tend to develop his or her own variations of the technique" (ibid. p.662).

4.4.3 Alternative Approaches to Data Analysis

Grounded Theory is a rigorous method in qualitative research and requires skill and commitment to do it properly and authentically (Payne & Payne, 2004). Whilst not all qualitative researchers become grounded theorists, there is a widespread use of analytic techniques common to Grounded Theory, such as coding, memo-writing and thematic analysis. Richards (2009) refers to "data theory bootstrapping" as a way of describing the analytical process of coding, exploring, relating and studying data which is then interpreted in relation to theory, explaining how the qualitative researcher has to construct a theoretical account from often small and meaningful data, interlinking small grains of data with each other to make larger data "chunks" to be interpreted and from which theory can be built.

King and Horrocks (2010) outline a basic approach to thematic analysis as a system of ordering data in both hierarchical and relational ways through descriptive and interpretive coding and conceptualization of overarching themes at a higher level of abstraction, a similar framework to that suggested by Corbin and Strauss (2008). They suggest a continuum of thematic analysis with Grounded Theory taking a "bottom up" approach to data interpretation whereby data is thoroughly explored and revised until a

full understanding is reached ("theoretical saturation") and Matrix Analysis at the opposing end, a "top down" approach to data interpretation using *a priori* themes and allowing for little modification, revision or iterative reflection during the analytic process. Template analysis (King, 2004) stands in between the two extremes of the continuum and involves the development of a hierarchical coding structure that is iteratively applied to the data using a mix of *a priori* and *in vivo* themes, where themes represent instances of higher order codes, rather than aiming to move towards greater abstraction and conceptualization as with Grounded Theory.

King (2004) suggests that template analysis can be used within a range of epistemological positions and "may be preferred by those who are not inimical to the assumptions of Grounded Theory, but find it too prescriptive in that it specifies procedures for data gathering and analysis that must be followed; in contrast, template analysis is, on the whole, a more flexible technique with fewer specified procedures, permitting researchers to tailor it to match their own requirements" (ibid. p.257). The flexibility of template analysis accommodates the "messy" and sometimes unpredictable nature of qualitative research (Crotty, 2003; Knight, 2002). This approach to data analysis is appropriate to this research.

4.5 My Chosen Methodology

Having given an overview of the methodological and analytical issues in qualitative research, I will now explain which approach and methods I have applied to this research.

4.5.1 Approach and Methods

The approach I have taken is in line with Stake's (2000) definition of intrinsic case research, focusing on the experiences of individuals within a single organisation, an NHS Acute Trust. There are seventeen individuals within the research site who are the "units of analysis" and the primary data source for this research, sixteen Modern Matrons and one Director. These individuals have been purposively selected as they are central actors in the research setting and "have a special contribution to make because they have some unique insight because of the position they hold" (Denscombe, 2007,

p.189). The Modern Matron is a new role in the organisation hence provides valuable insight into role and identity construction within the workplace. The Modern Matrons in the case organisation are collectively responsible for leading on the implementation of national and corporate policies such as Essence of Care benchmarking. As leaders enacting policy, they contextualise, shape and frame the experience of Essence of Care benchmarking within the organisation, and through such action, both derive and attribute meaning (Smircich & Morgan, 1982) to their role and identity construction. The data provides opportunity to theorise conceptually from the lived experience of individuals working within the health care setting, drawing from this to offer new thinking on role transition and identity construction in health care organisations and more broadly (Denscombe, 2007; Hodkinson & Hodkinson, 2001).

The primary method of data collection I have used is semi-structured interviews as this intuitively felt like the most appropriate way through which to elicit the participants' own narratives on themselves and their work. The interview data has been supplemented by observational field-notes and a range of secondary source data in the form of policy and organisational documents where appropriate. The significance placed on self reflection in the ethnographic approach has influenced me to be explicit and open about my relationship with the research site before and during the research as this will have influenced the interactions and dialogue between myself and the research participants.

4.5.2 Data Analysis

It is clear from the literature that Grounded Theory is a highly acclaimed data analytic approach which ensures rigour and consistency in the process of analysing qualitative data. The sentiment implicit within the Grounded Theory approach is very appealing to me, the researcher, wishing to be systematic, rigorous and accurate in my representation of the data. However, I cannot claim that this research has adhered to the Grounded Theory process, for example, I have not been able to revisit participants or access new sites through which to further explore key themes that have arisen from initial coding, thus I cannot claim to have carried out theoretical sampling; to do so would be to risk being one of those studies maligned by Wilson & Hutchinson (1996, p.122) as detracting from "the credibility and value of authentic grounded theory." The limitations in

sampling, as viewed from the perspective of Grounded Theory, arise from the restrictions on access to participants placed upon the research by the Local Research Ethics Committee (Section 5.3.2., p.100).

When considering how to conduct my data analysis, I have been influenced by King's (2004) template analysis, and more broadly, the generic process of thematic analysis; ordering data through descriptive coding, hierarchically and relationally. I began with initial open coding, reflecting a hierarchy of themes and subthemes; these initial codes were then cross referenced with *a priori* concepts from theoretical literature, leading to further in-depth coding of the data. Taking an inductive approach to data analysis preserves the integrity of the data, staying close to the lived experience of the respondents, through their own words. I have found memos and personal notes to be a useful adjunct to the data analysis process.

4.5.3 Self Reflection

Qualitative researchers have been criticised for not being transparent about their choices and actions in conducting research (Bryman & Burgess, 1995), something that Lofland et al. (2006) refer to as "trueness" and "theoretical candor" in the collection and analysis of qualitative data. One aspect of this is the inevitable subjectivity of the researcher in the qualitative research process (Denscombe, 2007; Denzin & Lincoln, 2005; Miles & Huberman, 1994). Rosseau & Fried (2001) emphasise the importance of contextualising research, particularly in consideration of the "invisibility" of the researcher; what is implicitly known and assumed by the researcher needs to be explicitly conveyed to the reader. One way to provide such context is through rich description of: the research setting; prior research which has informed current research; and evaluating the role that time plays in the research process (ibid. pp.7-8).

In the spirit of contextualisation and transparency, and in recognition of my subjectivity as researcher, this is interwoven into a personal narrative about my "research journey", offering rich description of the research as it has progressed.

4.5.4 "Starting Where You Are"

Lofland et al. (2006) take a pragmatic view on how most researchers first engage with their research project, suggesting that by its very nature, social research places the researcher within the social setting that is to be observed and so most "start where they are" (ibid. p7). It is a combination of "intellectual curiosity about a topic" and "access to settings and people from which one can collect appropriate data" (ibid. p.9) that generates the research proposition, realised when the researcher brings the "research setting and subject together with an intellectual and analytic agenda" (ibid. p.9). This has been my experience.

The initial motivation for this research emerged out of personal experience gained when delivering training workshops on service improvement in general, and more specifically benchmarking, to health and social care professionals during the period 2001-2005. My knowledge and experience of service improvement and benchmarking derives from the field of operations management, and specifically quality management. I was seconded to an NHS funded organisational development (OD) agency delivering a programme of service improvement training to local NHS Trusts, covering a range of topics, including change management, quality improvement and benchmarking. During this period, benchmarking was something of a "hot topic" as 'Essence of Care' had just been launched. The benchmarking training offered by the OD agency to which I was seconded became very relevant and timely.

The initial response from staff within the NHS was a need to understand what benchmarking was; how Essence of Care benchmarking had been developed; for what purpose and how could it be implemented within and across NHS organisations. Policy guidance was non-prescriptive and ambiguous, which was a cause for concern amongst health care practitioners at the time.[3] The primary aim of the workshops was to demystify benchmarking for health care practitioners, introduce benchmarking theory in a practical and meaningful way and offer pragmatic ideas and solutions on how to implement benchmarking in their context specific workplace.

[3] Personal Notes

I gained direct access to several NHS organisations, providing benchmarking training and development. In a couple of organisations this involvement was extended to include ongoing support for initial implementation of Essence of Care. The overwhelming issue that repeatedly arose was a desire by health care professionals to understand benchmarking theory and 'translate' this into the health care context.

A colleague and I conducted a small-scale evaluation with one client organisation to assess the impact of the benchmarking training we had delivered (Matykiewicz & Ashton, 2005: Appendix D). Our findings emphasized the importance of leadership and support; strategic direction; effective communication and appropriate resourcing as central to successful implementation of Essence of Care. It also highlighted the need for a "receptive context" for change at the micro organisational level (Pettigrew et al., 1992). The interactions I had with health practitioners highlighted the perceived difficulties of translating theory into practice, the need to understand and accommodate a nationally driven, standardized performance management tool within a local context and the apparent discord between functional management devices and the social context into which they are implemented. At this point, I decided to embark on this PhD, with a proposal to explore how health care practitioners made sense (Weick, 1995) of Essence of Care.

4.5.5 My (un)reflective Self

My initial research aim was to explore what happens when a formal, mechanistic quality improvement tool (Essence of Care) is imposed (by Government) on an organic entity, i.e. the organisation, comprising individuals and groups, with different motivations, interpretations and sense-making (Morgan, 1997; Weick, 1995).

A retrospective view of the initial proposal shows how managerialist I was in my thinking at this stage, perhaps reflective of my role as 'policy advocate' working on behalf of the institution of the NHS. This will have tacitly influenced my thoughts and actions in relation to the research proposition and design. An extract from my Initial Proposal form illustrates an unquestioning acceptance that quality reform practices will improve patient care,

> *One challenge they face is in understanding, interpreting and making sense of what quality reform really means – how it translates into their every day job, in improving care for patients and services for user.*
>
> (Initial Proposal Application, October 2003)

My perceptions have shifted during the PhD process and I would now question this implicit acceptance of managerialist rhetoric. More significantly, the original emphasis on the importance of leadership has developed into an in-depth study of how leaders, in the form of Modern Matrons, are made, develop, change and emerge.

4.6 Concluding Thoughts

This chapter has considered qualitative research methodologies and methods, with a view to positioning this research, ensuring that it is epistemologically sound and that appropriate methods have been chosen to collect and analyse the research data. Whilst there are numerous ways by which to conduct research of this nature (i.e. highly contextual, experiential and interpretive), I have taken an intrinsic case approach, focusing on the experiences of purposively selected individuals within a single organisation. The primary method of data collection has been semi-structured interviews through which a detailed and rich set of data has emerged. In addition to the primary interview data source, I have also made use of other data sources in the form of personal and observational field-notes and official documents.

I believe I have made an honest attempt to undertake sound, robust research; I have been transparent and candid about the methodological choices I have made, articulating the reasoning behind decisions I have taken (Eaves, 2001). The chapter that follows describes how I have conducted the research with the case organisation; this is written as a personal narrative through which I contextualise the research setting and offer a reflexive perspective on my subjectivity within it (Denzin & Lincoln, 2005; Rosseau & Fried, 2001).

5 CONDUCTING THE RESEARCH: THE CASE ORGANISATION

As explained in Chapter 4, I was working within the NHS and had prior involvement with the case organisation. It is this social setting for the research which I will now describe. This research took place in a large Acute Trust with over 10,000 staff working across multiple sites. The Trust delivers secondary care to a large local population (over 250,000), as well as providing tertiary specialist care for patients across the wider UK population. The Trust has strong links with the region's medical schools and universities providing medical training and research.

5.1 Organisational Structure

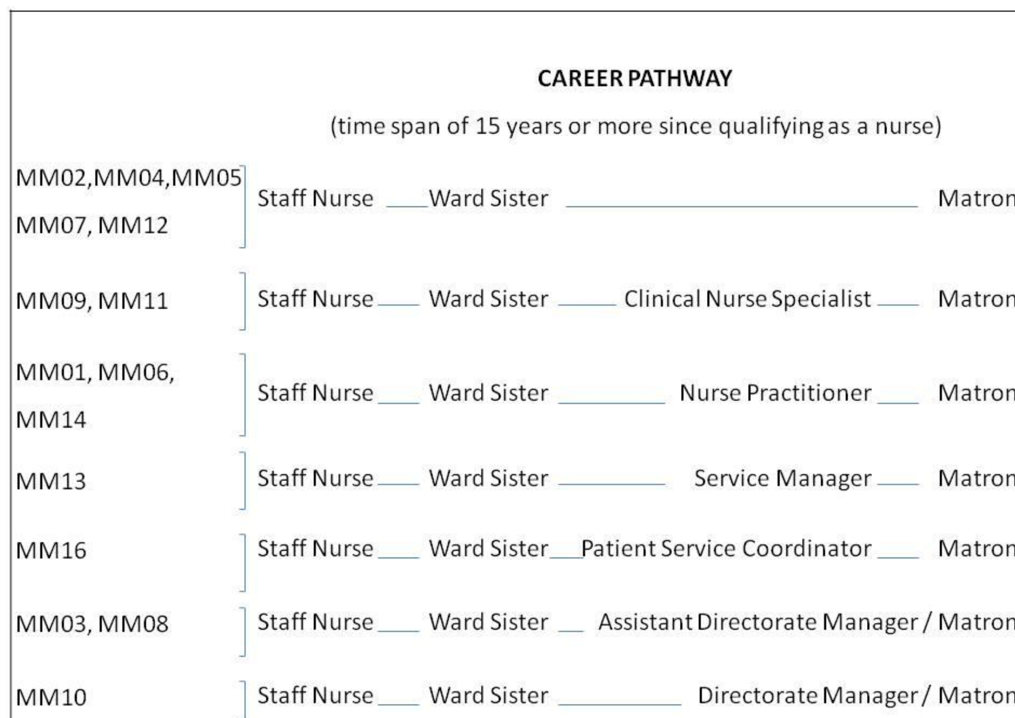
At a very simple level, the Trust Board sits at the top of the organisational hierarchy and comprises Executive Directors (Chairman, Chief Executive, Finance Director, Chief Operating Officer, Nursing and Patient Care Director and Medical Director) accountable for the overall management of the Trust; and Non Executive Directors who are responsible for scrutinizing the performance of the Executive Directors, holding them to account for the delivery of the strategy agreed by the Board. My sponsor in the organisation, D1, is an Executive Director on the Trust Board. At the time of data collection, she held the title Director of Nursing and Patient Services. This title has since changed to Nursing and Patient Care Director.

Reporting to the Trust Board are two Heads of Nursing based across the Trust sites, and who have professional responsibility for all nursing staff within the Trust. Also reporting to the Trust Board are Clinical Directors and Directorate Managers for each specialty service; there are twenty three specialty services, known organisationally as directorates.

A Modern Matron works within each directorate, in this organisation, they have chosen to use the title Matron; I gained access to all of the Matrons I could within the parameters of ethical and organisational constraints and interviewed sixteen of the twenty three Matrons in the Trust, the remaining seven opted not to participate. The Matrons are all senior nurses, each with more than 15 years nursing experience; some progressed from junior to senior nurse within one clinical area; others progressed

through their nursing career working across different clinical specialties, in a variety of roles, including research and lead specialty posts as shown in Figure 5.1:

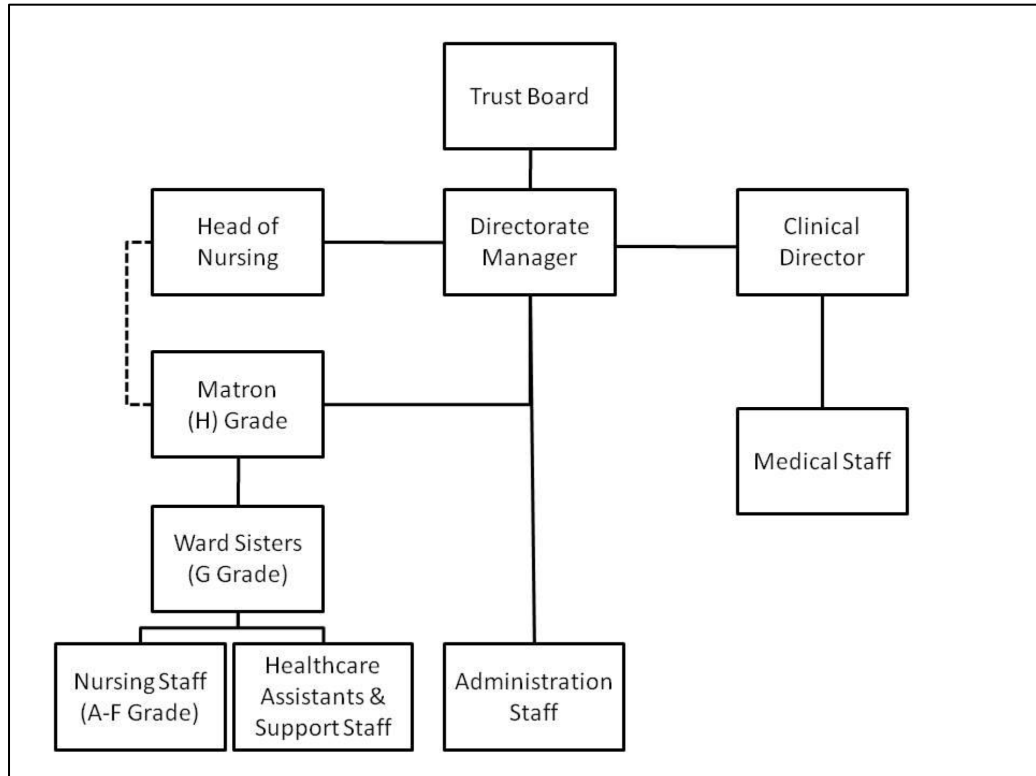
Figure 5.1: Respondent Career Pathways



In general, directorates are operationally managed by a Directorate Manager. The Matron provides clinical leadership to, and management of, nursing staff whilst the Directorate Manager provides operational management; in some instances, the post-holder will not have a clinical background and will work closely with Matron who gives clinical support. Matrons report professionally to the Head of Nursing and operationally to the Directorate Manager. The nursing staff within each directorate report through the nursing hierarchy[4], from most junior nurses to ward sister (Grade G). Ward Sisters report to Matron (Grade H). Non-clinical staff (e.g. administrative and support staff) report to the Directorate Manager. Each directorate has a Clinical Director and all medical staff report to the Clinical Director who, in turn, reports to the Medical Director on the Trust Board, this generic organisational structure is illustrated in Figure 5.2:

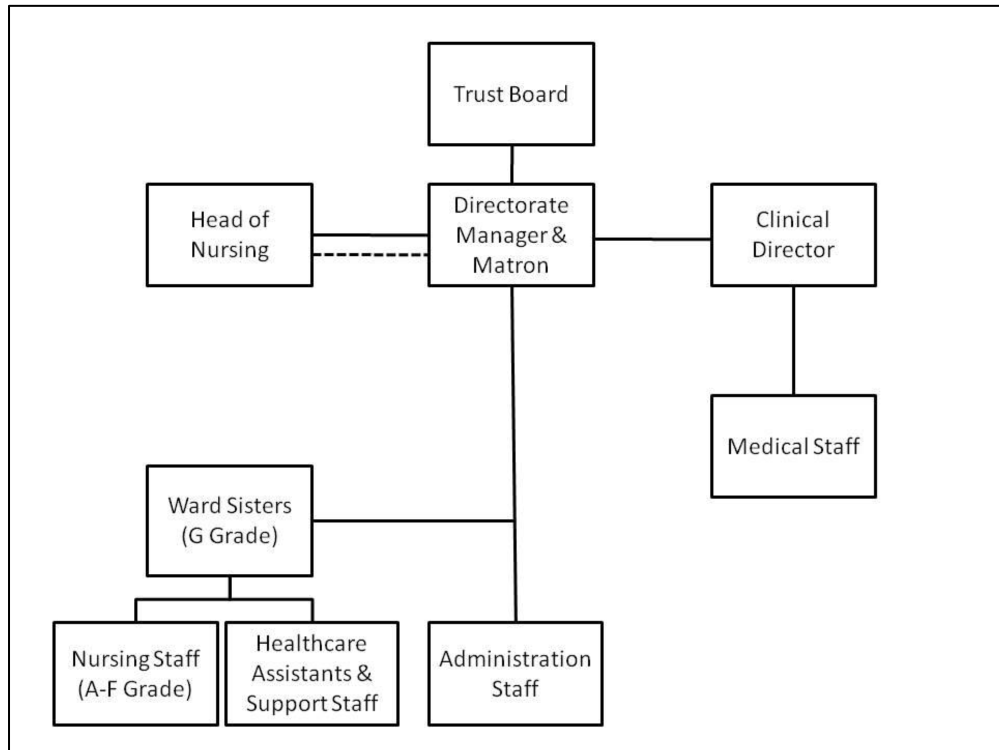
[4] Agenda for Change (AfC) launched in 2004, integral to NHS reform; it is a new pay and grading system. At the time of this research, the new AfC pay structure had not been implemented in the Trust although it was a primary concern for the Matrons. The respondents talk in terms of the traditional Whitley clinical grading system: A-B unregistered (e.g. health care assistant); C-E registered (e.g. staff nurse); F junior/deputy ward sister/manager; G ward sister/manager; H/I senior nurse/specialist nurse. Source: http://www.nhsemployers.org/payandcontracts/agendaforchange/pages/afc-ataglancerp.aspx date accessed: 08-Apr-2011

Figure 5.2: Generic Organisational Structure



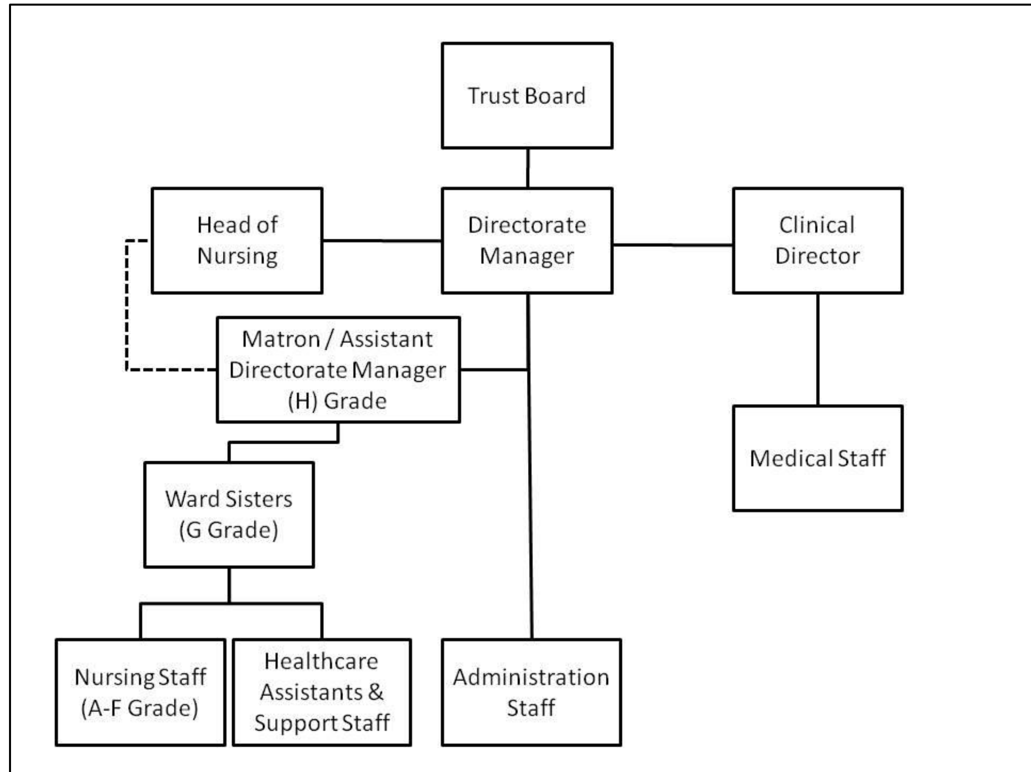
However, not all directorates share this organisational structure. Figure 5.3 depicts arrangements for the Matron in Dermatology. In this case, the Matron has dual responsibilities as Matron and Directorate Manager. All staff report to her and she reports on operational issues to the Trust Board whilst also reporting professionally to the Head of Nursing:

Figure 5.3: Organisational Structure (Dermatology)



Meanwhile, Figure 5.4 illustrates the organisational structure for Surgical Services and Cardiothoracic Services. In these two cases, the Matron has dual responsibilities as Matron and Assistant Directorate Manager, with line management responsibilities to all staff, and reporting to the Directorate Manager:

Figure 5.4: Organisational Structure (Surgical Services & Cardiothoracic Services)



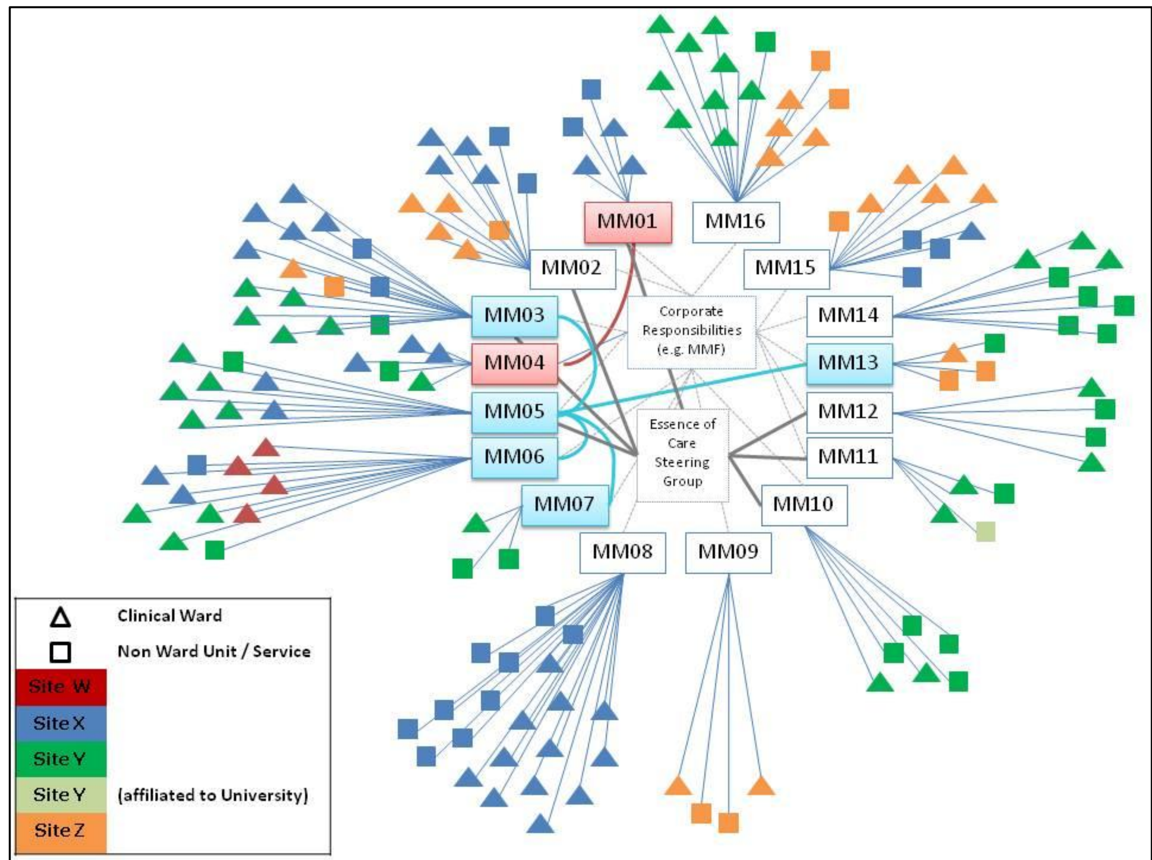
The differences between directorates in terms of organisational structure, reporting lines and the Matron's position highlight issues in relation to the managerial versus professional dichotomy; role dynamics between the Matron, other senior roles and junior nursing roles; and how reporting lines are interpreted in practice. These are issues pertaining to power, authority and professional identity; a more detailed discussion of which follows in Chapters 6, 7 and 8.

5.2 Organisational Complexity

Whilst the organisation structures above have been depicted very simplistically, this belies the complexity of the environment within which the Matrons work. Each directorate comprises numerous clinical wards and non-ward based units (e.g. outpatient departments, day clinics, specialist services) for which the Matron has clinical leadership responsibility. Figure 5.5 attempts to illustrate this organisational complexity by

showing the geographic location(s) and nature of services for which each Matron has responsibility:

Figure 5.5: Matron Areas of Responsibility



Geographically, the Trust covers a large city with several hospital sites, depicted here by colour coding. As illustrated, half of the Matrons interviewed work across multiple geographic sites, whilst others remain within one location; both have implications on the interactions that they have within and across organisational boundaries (Read et al., 2004). There are approximately 3500 nursing staff employed by the Trust and distributed across each directorate; some Matrons have responsibility for larger staff numbers than others depending on the nature of the clinical specialty and size of directorates; as an example, the Matron for musculoskeletal services (MM02), a medium sized directorate, specified that she has line management responsibilities for approximately 250 nursing staff.

Each directorate comprises a mix of ward based or non-ward based units and services, for example, outpatients department, day clinics, or specialist services and this varies depending on the nature of the clinical specialty; Accident and Emergency (MM13) is an outpatients department with high throughput of patients (Trust Annual Report, 2009/2010) whilst Elderly Care Services (MM06) tend to be ward based, long term patients.

Whilst the number of wards and units that a Matron may be responsible for varies significantly across the Trust, this does not reflect the volume of patient activity or the specialised, technical nature of each directorate. Each of the Matrons with four or less wards/units (MM07, MM09, MM11, MM13) work in highly specialised clinical areas (Cancer Services, Gynaecology, Coronary Care) and/or areas with high volume of patient activity (Accident and Emergency). Where clinical specialties are linked, there is cross-directorate working between the Matrons. For example, MM01 (Urology) and MM04 (Renal Services) work closely together. Meanwhile, MM05 (Internal Medicine) has an additional overall management responsibility for several Matrons where the clinical speciality falls under the umbrella of Internal Medicine; these are MM03 (Surgery), MM06 (Care of the Elderly), MM07 (Coronary Care) and MM13 (Accident and Emergency). All the Matrons have corporate responsibilities for example, involvement with specialty specific and Trust wide working groups, attendance at Senior Nurse Meetings and the Modern Matron Forum (MMF).

These variations in geographic location, size of directorate, nature of specialty and type of provision (e.g. in hospital ward based care or outpatients day clinic) lead to differences between individual Matrons in terms of the organisation and interpretation of the role at directorate level; these differences are manifest in each individual's account of their role in practice and have relevance to their identity construction (Brewer, 2001), to be discussed in more depth in Chapter 6.

5.3 Getting Started with PhD Research

This section describes the first two years of the research. My research proposal emerged from a culmination of several interventions with NHS Trusts, including the case

organisation, in relation to making sense of and implementing Essence of Care benchmarking. My involvement with the case organisation had been a positive experience, with a good working relationship between client and myself and visible progress made in relation to objectives set.

The organisation presented as an ideal research site for further exploration of the implementation process; I had been involved at the outset of the process and understood the organisational structure across which the Essence of Care benchmarking would be rolled out. More pragmatically, I was known to the organisation which helped enormously in gaining access for my research data collection (Knight, 2002; Lofland et al., 2006). The case organisation was local to my place of work and home hence appealing in terms of practically getting to and from the research site.

5.3.1 Being Known to the Research Site

Prior to this research, I facilitated a benchmarking programme which involved delivery of two 3-day workshops over a period of nine months (Cohort 1: February - April; Cohort 2: July - October 2003). Each 3-day session was attended by a cohort of six senior nurses, a mix of Matrons and Ward Sisters, all of whom had responsibility for implementing Essence of Care benchmarking within their directorate. The overall aim of the programme was to assist the Trust with their implementation of Essence of Care.

The workshop setting enabled staff to "take time out" of their busy day-to-day work environment to be able to concentrate on working together, to plan a way forward for implementing Essence of Care that would be timely, relevant and strategic. Feedback from the programme[5] suggested it had been beneficial in a number of ways; in offering a theoretical framework for benchmarking activity; in giving protected time out to consider relevant issues; in developing skills and confidence of staff to act and in helping the cohorts to make progress with their implementation plans.

As a facilitator to the cohort members I was in a privileged position, where developing trust and adhering to confidentiality were of paramount importance. From this unique

[5] Programme Evaluation documentation

position, I was able to observe directly the issues of policy implementation when performed at the micro-level in the organisation. At the end of October 2003, the Essence of Care steering group was in operation, documentation had been piloted and a standardised process for benchmarking agreed. Staff engagement was being tackled as illustrated by a series of awareness raising activities held across the Trust. One of these was the Essence of Care Awareness Day to which I was invited to give a presentation.

5.3.1.1 Essence of Care Awareness Day

This event launched the Trust's standardised approach to clinical benchmarking, the result of work by the Matrons and ward sisters who had attended the facilitated programme and who were instrumental in setting up the Trust's approach to Essence of Care. Members of the Essence of Care steering group led and facilitated group sessions to familiarise delegates with the standardised benchmarking documentation that had been developed with an invitation for delegates to give feedback on this, emphasising that the implementation approach is an experimental and iterative process (Matland, 1995). The awareness day evaluated well and this was in turn seen as signifying the combined efforts of the facilitated programme, Essence of Care steering group, senior management support and staff involvement as demonstrating real organisational success in the first stages of implementation.[6]

This was the last event that I attended in the capacity as a benchmarking facilitator working on behalf of the OD agency and contracted to deliver support and facilitation to the client organisation. The relationship I had formed with this Trust through my role as an external facilitator, by knowing the Head of Nursing and Patient Services personally and by having gained the trust and confidence of the Matrons and Ward Sisters involved in the facilitated programme proved invaluable as I embarked on my own PhD research.

To summarise, while the subsequent interviews were singular in nature (with respect to each Matron) the prior contact meant that relations were already established with many informants, to the extent that a level of shared understanding and trust was already in place, thus facilitating in-depth exploration of their experiences.

[6] Correspondence from Trust

5.3.2 Gaining Access: Ethical Approval

I approached my sponsor in the organisation, the Head of Nursing and Patient Services (D1), with an initial request to discuss the possibility of using the organisation as a case study for my own PhD research. The response was immediately positive which encouraged me to request permission to conduct the research at this organisation from the Trust's own research committee and the Local NHS Research Ethics Committee (LREC). My diary notes read,

> *Had a good meeting with [D1] re: PhD. Fired me up to continue with PhD research. Also tackled the LREC form today, it's really detailed (57 pages) and has highlighted that I need to be much more detailed about the research. Lots of work needed on this before I can go into the Trust.*
>
> *(31st March, 2004)*

The NHS has an understandably rigorous approach to safeguarding patients and staff participating in research by ensuring all research plans are ethically sound. In 2004, the Research Ethics Committee process involved the submission of a detailed application form reviewed by the LREC panel and an interview with the LREC panel to discuss the application prior to a decision being made as to whether to allow the research to proceed, this included stringent assessment of who I could speak to, when, where and how. This process took 8 months from application (April, 2004) to approval (November, 2004) which felt like a significant delay to getting started with the research. My application for access to interview the Modern Matrons within the organisation was approved and I was able to make contact with the case organisation and conduct the research on site.

5.3.3 Data Collection: Points of Contact with the Case Organisation

My choice of methods for data collection has been outlined above (Section 4.5.1, p.85). Here I describe in detail the points of contact I had with the organisation, which were in line with LREC requirements.

5.3.3.1 Observation of the Modern Matron Forum

My initial point of contact was by invitation to attend a Modern Matron Forum meeting (17th May, 2005) at which I presented my research proposal and invited volunteers to participate in the research. The response I received from this first meeting was positive with sixteen Matrons agreeing to participate,

> *My presentation went OK. Some positive feedback but some reservations in room regarding interviews – purpose and focus. Have explained I'll need some personal background for context – to tell the story of how they got here and where Essence of Care fits into work tasks etc.*
>
> *(Diary Note, 17th May, 2005)*

I attended one other Modern Matron Forum meeting, the following month (June 2005) for the purposes of observation. It presented an opportunity to clarify my research proposal and make arrangements for research interviews with individual Matrons but, more importantly, gave insight into who the Matrons were and the nature of the work and key issues they face in their role as communicated within this forum. Much of the discussion focused on policy implementation, such as infection control; liaison with Trust facilities such as portering, catering, equipment and transport for awareness raising and to facilitate policy implementation; issues for staff development, particularly with reference to Agenda for Change were also discussed.

5.3.3.2 Research Interviews

The primary data collection method used in this research is semi-structured interviews. In January 2005, I conducted a pilot interview with a Modern Matron at a different NHS Trust where I tested out a draft interview schedule. This 'practice run' proved invaluable in helping to refine the interview topic outline before conducting the research interviews.

During the period July – October 2005, I conducted interviews with seventeen individuals in the case organisation; the Head of Nursing and Patient Services and sixteen Matrons within the Trust. After an initial Letter of Invitation (Appendix E) to

participate in the research, individuals made contact with me directly to confirm their willingness to be involved. I then liaised with each participant by email to arrange the time and date for the interview.

Prior to the interview, the participants received a Participant Information sheet (Appendix F) detailing the nature of the research. Each participant signed and returned the consent form (Appendix G) before the interviews took place. Interviews were held on Trust premises, either in the participant's office or in a meeting room booked specifically for the purpose of interviewing for this research.

All interviews were recorded using a minidisc recording device and microphone. The advantage to recording the interviews is that I have a complete record of all that was said in the course of the interview and this is a permanent record (Denscombe, 2007; Knight, 2002). The minidisc technology offered a high quality of sound recording and the long play facility gave up to three hours of uninterrupted recording. The recording equipment was relatively small and unobtrusive and once set up could be put to one side. Inevitably, the fact of being recorded was in the consciousness of both participant and myself as researcher but "did not pose too much of a disturbance" (Denscombe, 2007, p.195) during the interview process.

In addition to recording, I took notes during and immediately after each interview to capture any unseen non-verbal communication and contextual factors of relevance to the interview (Denscombe, 2007). In some cases, when interviewing in the participant's own office, there were interruptions by phones ringing or people knocking on the door. At these times, I paused recording and waited for an appropriate time to resume the interview. One participant had to postpone the interview; in this case, we rescheduled and met at a later date. One other participant had been unavailable to meet but was prepared to give a telephone interview. In this case, I used a telephone microphone and minidisc recorder to record the interview; whilst I was unable to pick up on visual cues during the telephone interview, it still enabled a two-way dialogue (Denscombe, 2007) which I believe to be more valuable than potentially losing this respondent's input altogether.

An interview guide with eight ‘discussion topics’ and associated prompts was used during each interview to guide a conversation between the participant and myself, open ended questioning encouraged participants to speak freely around the prompts given (Appendix H). The questions and responses arising from the prompts took individual interviews in different directions so, whilst most areas of the interview guide were covered, there is variation in how, and at what stage in the interview, the participants have responded to them (Saunders et al., 2000).

The first question I asked each respondent was to “describe your current role to me” with prompts about key responsibilities, what they enjoyed and what challenges they might face in the role; this was intended as a question that would ‘break the ice’ and put the respondent at ease given the familiarity of the subject to themselves. The question which followed naturally from this was “tell me how you came to be in this role” which elicited personal career histories and deciding influences in their career path. As respondents would tend to talk about their clinical leadership responsibilities at this point, this would lead to a prompt to “tell me about working with others”, encouraging descriptions of reporting lines, working relationships and a question about who they regarded as their ‘peers’. Discussions about peers tended to focus on working with other Matrons and the organisational structures by which they do this, namely the Modern Matrons Forum and other working groups, such as the Essence of Care steering group.

At this point, it felt appropriate to ask respondents to “tell me about Essence of Care benchmarking,” including prompts about “putting it into practice” and the Trust’s approach to implementation; their personal views on this and perceptions they had of others’ views. There were two questions on the interview schedule that were less utilised: first, “tell me what this Trust is like” prompting for opinions on the organisation as a whole, its priorities and its approach to organisational change. This question was often unnecessary as respondents tended to have shared their views of the organisation in the course of describing their role and working with others. Second, a question about any critical events that had occurred that were felt to be essential to the implementation of Essence of Care within the Trust tended not to reveal much more than had already been said.

Some of my personal reflections during the data collection period are shown below:

> *I have to suspend my assumptions about implementation of Essence of Care and instead listen to what I am being told by the Modern Matrons. For example, the highly structured approach taken within this Trust is positively received, which makes me question the dichotomy between mechanistic and organic. Maybe Essence of Care has worked here because of the mechanical structured process? (Personal Notes, 11th Aug 2005)*
>
> *There is something about an unquestioning acceptance of Essence of Care as a good thing. Little challenge to the factors within it or the reason it has been introduced. Need to explore this more. (Personal Notes, 2nd Sept 2005)*
>
> *There might be something around nurse training of 20 years ago (students then, Matrons now) and now – more academic, less patient contact. A strongly held set of beliefs among Matrons – is this shared with other staff, more junior, newer? (Personal Notes, 29th Sept 2005)*

These illustrate the inductive nature of the research as the data begins to give clues to issues of personal values and affirmative action in support of self and identity. It also indicates a change of focus for the research in which the nature of nursing and the place and identity of the Matron as an organisational actor, policy instrument, professional nurse and person begin to take shape.

5.4 Transcriptions and Initial Coding

Knight (2002) has described the messy, tangled, non-linear aspects of doing research as the "edge of chaos" (ibid. p.161) which I feel to be an apt description. In between data collection and data analysis I took a break from the research for family commitments. During this time I maintained limited contact with the research where the main priority was to organise the data in a meaningful way.

It is well documented that one hour of talk can take several hours to transcribe (Denscombe, 2007; Saunders, 2000). I had approximately 17 hours of interview data to transcribe (Appendix I) and I took a pragmatic decision to use a trusted and known transcription service, on recommendation from a colleague within my department at work. The transcription service has experience of transcribing health research data and assured confidentiality. The transcriptions were "verbatim" and, for quality assurance, I checked each transcript against the original recording. There was a high degree of accuracy in the transcriptions and the process of listening to each recorded interview whilst checking the transcriptions brought me "closer to the data" (Denscombe, 2007, p.196).

It is possible that the mechanical process of transcription leads to a loss of authenticity of data (ibid. p.199). I take the view that whilst nuances of verbal communication (e.g. pauses, intonation) may not have been transcribed I have repeatedly listened to the recordings whilst reading the transcripts and so have a feel for the expressions and emphasis in the data. For me, the benefits to having the data in a format that lends itself to analysis far outweigh the drawbacks of the transcription process. At this point I began analysing the data using open coding to generate descriptive, hierarchical themes and sub-themes (Appendix J; Appendix K).

5.4.1 Initial Coding

The research process is an iterative interweaving of data collection, focusing data and analysis (Bryman & Burgess, 1994; Lofland, 2006) often with these tasks working in parallel with each other.

At the time of conducting the interviews, I had an expectation that, based on my prior knowledge of the challenges experienced by practitioners in implementing Essence of Care, the data would present as mixed responses to the process of benchmarking in the Trust. Had I attempted to analyse the data at this same point, I might have heard what I expected to hear. However, the interlude between data collection and data analysis meant I had been distanced from my role as benchmarking facilitator for some time which enabled me to be more objective towards the transcribed data giving the

advantage of listening to the data as if for the first time and reflecting upon it with an open mind.

The inductive nature of *in vivo* coding began to emerge an unexpected but significant emotive response to Essence of Care. Further analysis of this led me to consider issues of clinical leadership and more specifically role, identity and action in the figure of the Modern Matron as it both related to and went beyond Essence of Care. As well as asking "how do Modern Matrons make sense of Essence of Care," a second question emerged; "how does Essence of Care constitute the Modern Matron?"

5.5 Reframing the Research

The identity theme revealed by the initial coding of the data led to a reframing of this research. With the guidance of my supervisory team, I took a decision that I had sufficient data to enable a thorough exploration of the researchable questions and that I would not need to collect more data to fulfil the remit of this thesis.

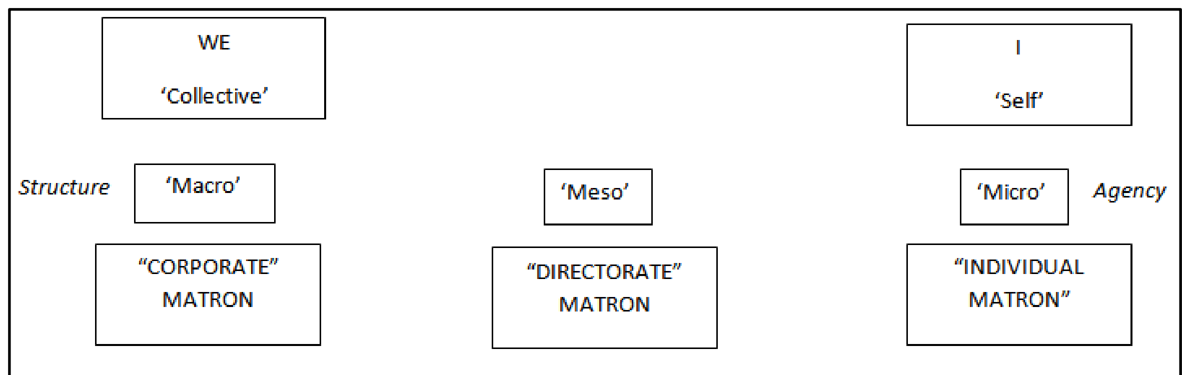
The reframing of the research to focus on professional identity of the Modern Matron required me to familiarise myself with the broad, multi-disciplinary and complex literature on identity; this has taken me in a completely new and exciting direction in terms of my own knowledge base. Having read the literature, I refocused the data (Lofland et al., 2006) in relation to relevant theoretical concepts around identity; for example, professional authority, autonomy and relational dynamics (Appendix L). This refocusing of the data entailed cross referencing data sets from initial codes with abstract concepts; my interpretation of template analysis, (King, 2004) bringing together of *a priori* theoretical concepts, as described in the literature, with *in vivo* themes as emergent from the data.

I reviewed the data extracts from the hierarchical thematic *in vivo* coding (for example, 3.2 Matron Responsibilities) and looked for instances in this data which related to theoretical concepts (for example, "autonomy" and "authority"). From this, I developed a set of more focused data upon which I have concentrated in the discussion of findings.

5.6 Organising the Data

I began to organise my data by creating a matrix structure (Figure 5.6) which I felt best reflected the core themes emerging from the in-depth focused analysis. This matrix incorporates fundamental theory of self and identity, distinguishing between the collective 'WE' and individual self, 'I'. The respondents' talk can be thematically analysed in relation to collective or individual thought and action. The commonly applied differentiation between macro, meso and micro levels of organisation (Currie et al., 2010; Pope et al., 2006) seemed useful as a way to consider issues of structure and agency and appeared as a natural fit with the data itself as the respondents talk of themselves across different organisational levels, corporate, directorate and individual.

Figure 5.6: Data Analysis Matrix



At a first glance, this appeared to be a neat framework around which to create the discussion of findings. However, the use of macro – meso – micro level of organisation makes this matrix intrinsically hierarchical, structured and linear as it presumes macro organisational issues working above and impacting down on micro organisational issues with the meso level mediating between the two. I had inadvertently created a pseudo hierarchy which did not "fit" with the theoretical propositions of identity construction being relational and interconnected across dimensions of organisation, collective and individual.

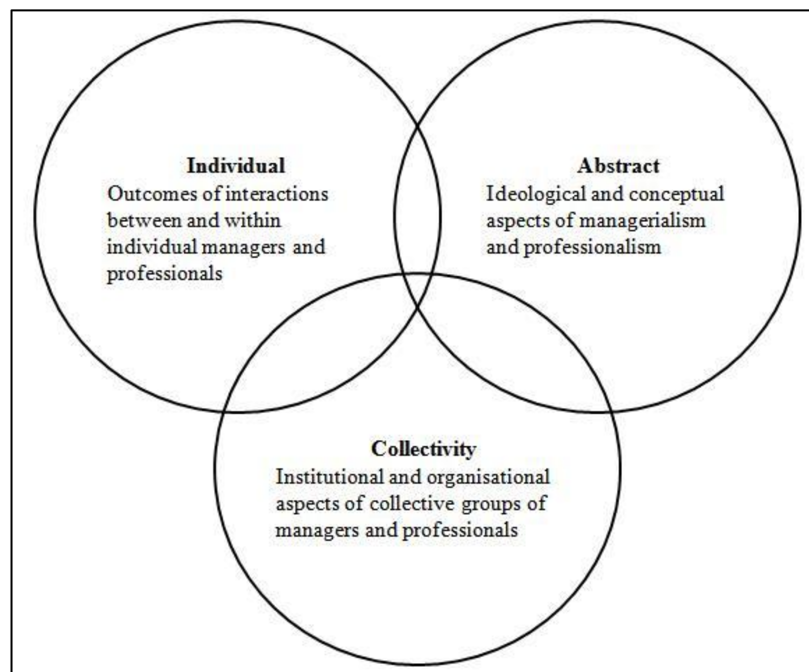
It was at this point I came across a heuristic framework (Figure 5.7) which describes three dimensions of professional-managerial relations as they occur in the research

literature and which are interconnected and relational (Exworthy & Halford, 1999, p.129). The framework has been devised as an aid to "seeing and interpreting the articulation between professionals and managers, as individuals, as groups and in abstract terms" (ibid. p.127).

This immediately offers an alternative framework through which to interpret and organise my data by maintaining the dimensions of individual interaction (agency perspective) and collective organisational/institutional aspects (structure perspective) whilst explicitly recognising the inter-relational aspects of these dimensions. It also offers the abstract dimension pertaining to ideological and conceptual aspects of role and identity which my original matrix did not account for; and which, as can be seen in the discussion of findings, are instrumental in Modern Matron identity construction.

Figure 5.7: Three Dimensional Analytical Framework

(Source: Exworthy & Halford, 1999, p.129)



Exworthy & Halford (1999) designed this heuristic framework with the intention that it be applied to large scale comparative studies of professional-managerial relations in

public management, across sectors and between countries. Clearly, I am not using it in this context however I find it has relevance to the micro-scale research I have conducted as it has helped me to make sense of the research data and organise these in relation to the subsequent discussion of findings (Chapters 6, 7, & 8).

5.7 Temporality in the Research Process

It is important to reiterate that this research focuses on the experiences of Modern Matrons within the Trust at a specific time in the organisation's history. As time has progressed, some of the issues and challenges that the respondents talk about will have inevitably changed, given the nature and pace of reform in the NHS (Walshe, 2010).

At the time of data collection, the Trust was in a state of organisational flux, with imminent reorganisations due to re-modernisation plans, site mergers, Foundation Trust status and Agenda for Change. The organisation's Annual Reports, publicly available via the Trust website, give information on organisational structure, policy and strategic objectives. A review of the Annual Reports since 2005, the time of data collection, shows that;

- The Modern Matron role is still current within the organisation as demonstrated by searching the Trust website. It describes the role as,

> An experienced nurse who is a strong leader and responsible for supporting the development and translation of professional, operational and organisational standards into practice at a local level.
>
> (Source: Trust website. Date accessed: 13-03-2011)

- Essence of Care continues to appear in the Trust annual reports as an ongoing, embedded activity as illustrated here,

> A further cycle of the *Essence of Care* benchmarking initiative has been undertaken during 2008/09 and this continues to provide a consistent approach to improving quality and standardising nursing practice across the Trust. *Matrons, with multi-professional support, led on this initiative. It was split into 3 phases, which considered various aspects of care.*

(Source: Annual Report 2008/09 accessed online: Trust website, 13-03-2011)

These extracts illustrate that the Modern Matron role and Essence of Care benchmarking are prevalent within the organisation hence this research continues to have practical relevance in terms of the ongoing experience of organising. To this is added a deeper level of conceptual contribution derived from an in-depth understanding of the ongoing constitution of the identity of Matron as a modern organisational actor and artefact.

5.8 Concluding Thoughts

In an endeavour to acknowledge my subjectivity in the research process, I have attempted to contextualise the research through personal narrative of my research journey, interwoven with rich description of the research setting and a chronological account detailing research stages and activities carried out (Rosseau & Fried, 2001). This contextual narrative acts as preparation for the detailed discussion of the research data in relation to role, identity and action which now follows. The discussion of findings is presented in four parts:

Chapter 6 considers the complexity and diversity of the Modern Matron role, focusing on areas of difference and tension as experienced by individual Matrons as they perform their role. This leads to a discussion of perceived differences between individual Matrons: in role specification, organisation and performance; across competing discourses of managerialism and professionalism and within and between directorates as illustrated through the implementation of Essence of Care. The chapter culminates by suggesting that Matron is a highly individualised role, constituted through inter-relations with others at the level of the directorate; a relational identity (Brewer, 2001; Sluss & Ashforth, 2007). In Chapter 7, I discuss the significance of role relationships and inter-

relations with ‘others’ across occupational boundaries to the constitution of Matron identity through discursive acts of authority and autonomy; Chapter 8 discusses the data in relation to collective professional identity formation (Cerulo, 1997) as illustrated through action on Essence of Care. Chapter 9 offers a concluding discussion which brings the findings together; in drawing my conclusions, I argue for the concept of “syncretic action” to describe the constitution of Modern Matron identity, a result of uniting seemingly divergent and competing philosophies through the performance of policy implementation.

6 MODERN MATRON: A DIFFERENTIATED ROLE

This chapter explores Modern Matron role, focusing on areas of difference and tension as experienced by individual Matrons as they perform their role. First I consider the difference between traditional Matron and Modern Matron and the significance of professionalisation in nursing to career pathways. Second, I present the organisational positioning of Matron with particular note of the implications this has on Modern Matron's authority in comparison with traditional Matron and in relation to others. A discussion follows about the roles and responsibilities of Modern Matron and contradictions with policy rhetoric as Matrons strive to define their role and with it, identity. I then consider tensions between policy; organisational structures and person-based values with regard to professional and managerial discourses. The chapter concludes by suggesting that the Modern Matron is disparate and in conflict and that these tensions are mediated through various role relationships, constructing multiple relational identities within self, as individuals and group members, and with others in the organisation.

The data reveals the Matron role as complex, contradictory and varied, operating across multiple levels of organisation revealing similarity through shared responsibilities and at the same time, difference in the individual performance of those duties as expressed by one respondent,

> *I do have my corporate side of my Matron's role where I have to attend all of the meetings and they're putting in Trust policies, national policies. I have my directorate side as well, where I work within my directorate. Then of course I have my national head on for my [clinical specialism] as well, so I have a lot of things to bring together, and that sometimes can be quite difficult. (MM14)*

At the level of the individual Matron (Exworthy & Halford, 1999), competing discourses of managerialism, professionalism and care interweave as individuals "make sense" (Weick, 2005) of the self, role and identity.

6.1 The Traditional Image of Matron: a contemporary perspective

As previously discussed (Section 3.4, p.62), there is a strong historical legacy of Matron, a powerful image embedded within the public consciousness that provides a contextual background against which the new Modern Matrons must reconcile self and role, negotiating and legitimising their place in the nursing hierarchy.

The traditional image of Matron projects power and authority over subordinates; has seniority within the organisational structure and is a highly visible presence in the organisation. Populist images of Matron appear in the media and television communicating contradictory connotations of militaristic authority, status and control alongside subservience, duty and domestic service (Hallam, 2002). As Stephens (2002, p.322) recollects,

> The Matron of my memory was a person in a starched apron and lacy hat that walked the wards reducing junior staff to tears over unimportant issues such as which way the opening of the pillows faced, tidy but hardly a matter of life or death. This person headed up a hierarchy where everyone knew their place, and as a lowly person within this pecking order, you did not dare question or challenge.

Figure 6.1: Hattie Jacques as "Matron"

(Source: Daily Mail)

This image is encapsulated by the character of Matron played by actress Hattie Jacques (Figure 6.1) in the British "Carry On" comedy films of the 1960s and 1970s; an enduring image that has become synonymous with strict, authoritarian control and discipline on the hospital ward.

Matron began her career as a nurse and progressed up the hierarchy through demonstrating competence on the ward; she was an ambassador for high standards of

cleanliness, tidiness and quality in nursing care with the requisite authority to ensure these standards were upheld by all staff. She was feared in the organisation, by medics and junior staff alike, and used this reaction to achieve her objectives. Matron held incredible social power, was unafraid to use her authority, and was monarch of her domain, subduing male medical staff in a reversal of the traditional power relations (Matykiewicz & Baxter, 2010). What is seldom acknowledged is that the Matron was likely to be the most senior woman in the organisation (Hallam, 2002); whilst she was through the glass ceiling (Ryan and Haslam, 2005) nursing as a whole was far below it and in need of status enhancement, hence the move to professionalisation (Section 3.3.3, p.57).

6.1.1 Career Pathway

The career path for a Modern Matron today is very different to that of traditional Matron. Currie et al. (2009) describe the contemporary changes in nursing careers towards increased specialist clinical nursing roles (e.g. clinical nurse specialist, nurse practitioner, nurse consultant) which substitute traditionally medical roles, research and education roles and pathways into general management roles. For the most part, the Modern Matrons interviewed for this research represent the professionalised nurse having worked through the career pathway to reach a senior nurse management position. As shown in the previous chapter, Figure 5.1 (p.92), illustrates the range of positions held by respondents prior to the role of Matron. Five respondents have progressed directly from the Ward Sister role to Matron whilst the remaining eleven have experienced different senior nurse positions before taking on the Matron role; for example, MM16 took the position of Patient Service Coordinator when she moved from another Trust to the case organisation and whilst it took her away from clinical work, she comments that, "*it's probably the best career move I've ever made, because it gave me such an overview of the Trust, I got so much experience, I think everyone should do it, it should be like national service, everyone should be Patient Service coordinator.*" However, when the Matron post became available, MM16 chose to apply so she could return to the clinical environment. MM01 spent time out of acute nursing as a Nurse Practitioner in the community where she set up a nurse-led service; whilst a largely

positive experience, she chose to come back into the hospital as Matron because she "*missed the acute side, sick patients and being part of a team.*" Similarly, MM06 had worked as a nurse practitioner but found she wanted to return to nursing and the Matron role offered the opportunity to do that. Whilst the respondents have each taken slightly different pathways there is consistency across the data that a major motivating factor for becoming a Modern Matron is the emphasis on maintaining a link with nursing and clinical practice whilst also recognizing their nursing management skills attained as they have progressed through the nursing hierarchy towards senior nurse management.

Currie et al. (2009) suggest that the professionalisation project in nursing "lost out" (ibid. p.299) to the managerialist agenda; as general managers joined the health management hierarchy, senior nurses tended to move to nurse education and research roles or reverted back to clinical positions on the wards. This suggests that nurses are working within both a medical hegemony as well as a managerial hegemony.

6.1.2 Organisational Positioning

The variation in the implementation of the Modern Matron role across NHS Trusts is extensive (Read et al., 2004) with some positioning the role at senior level whilst others position it as a middle management role. In the case of Currie et al. (2009), the positioning of the role within middle management is problematic; within my data, one might expect the seniority of the Matron role in the organisational hierarchy to confer significant authority and power; however what emerges is a complex picture of negotiated authority, leadership by influence and earned credibility which emerge through inter-relations between the Modern Matrons and others. This will be discussed in Chapter 7.

As shown in Chapter 5 (Section 5.1, p.91), the Trust has identified the Modern Matron role as a senior nurse position but, unlike traditional Matron, not at the top of the nursing hierarchy; each Matron has two reporting lines, operationally to the Directorate Manager and professionally to the Head of Nursing. The Matron supports the Directorate Manager, providing expert knowledge and guidance when clinical matters arise; this is particularly relevant when the Directorate Manager is non-clinical by

background. The organisational positioning in the hierarchy is illustrative of the dominance of general management over nursing management (Currie et al., 2009). MM10 holds a different position, reminiscent of the traditional Matron position as a member of the senior management team, with direct reporting to Trust Board; however, this reporting line is for operational management issues as Directorate Manager; the nursing position remains subordinate to the Head of Nursing within the professional hierarchy.

The positioning of the Modern Matron role within the nursing hierarchy has significance to professional identity construction as issues of authority and status are brought to the fore. Before discussing how the Matrons perform the role, a greater understanding of what the role entails is required.

6.1.3 Corporate Role and Responsibilities

The key aspects of the Modern Matron role as stipulated in policy: to lead with authority; be visible; and promote high standards of basic care, are very similar to traditional Matron's remit and in this respect there is congruence between the traditional and new Matron role, and between the Matrons themselves. All respondents agree with the remit of Modern Matron to focus on nursing issues such as maintaining the a clean environment and managing infection control as one Matron explained,

> *The Government's Health Service circular which described what we should do was really quite prescriptive and really set us a mandate to follow and that was backed up by the patients' charter last year which really then focused on environment and infection that we really do need to improve and make a difference for the benefits of the service users. (MM10)*

There is an overall acceptance of the responsibilities assigned to the role, that the 10 key responsibilities (Figure 3.1, p.64) *"in the main were fine and we understood what was going to be wanted from the Matrons" (MM03)* and that,

> *They're all reasonable things to be responsible for, things that, as Matrons, we should be looking at… I don't think any of us said; well actually I don't think that should be part of my role. I think they were all things that were perfectly reasonable that we should be doing. (MM01)*

Currie et al. (2009) argue that the career trajectory towards specialist nurse and nurse management roles is incompatible with general nursing care at the bedside bringing into focus one of several contradictions within the hybridized Modern Matron role (Bolton, 2003; Savage & Scott, 2004). The Modern Matron is a nursing management role, indicative of professional and technical expertise but the remit centres on ensuring general nursing principles of patient care are maintained. Here corporate management rhetoric meets professional nursing discourse.

When asked to describe the Modern Matron role, the respondents talked generally of their position within the organisation; their responsibilities at directorate level to patients and staff and corporate responsibilities to the Trust, indicative of the relational nature of the role. Policy documentation emphasises the non-prescriptive approach to introducing the Matron role into each individual NHS Trust,

> *Trusts were given scope to design structures that best suited local needs. Some have taken the opportunity to create entirely new posts. Others have re-designed their senior nurse posts to embrace the new Matron role and responsibilities*. (DH, 2002, p.3)

Within their remit of clinical leadership, the respondents are involved with training and staff development; providing advice and support to nursing staff; maintaining professional standards; staff management; recruitment and, in some but not all cases, being actively rostered into clinical practice. They also talk about "corporate" responsibilities which include policy implementation (e.g. Essence of Care, Improving Working Lives, Agenda for Change); conducting cleanliness audits; managing the risk register; handling complaints; involvement on corporate-wide working groups and meetings. A small number of respondents have operational management responsibilities which include budgeting, finance, waiting times, policy review and control. The breadth

and scope of role and tasks undertaken by the respondents aligns with findings from other evaluative studies which report the many and varied interpretations of the Matron role between and within different organisations (Ashman et al., 2006; Dealey et al., 2006; Gould, 2008; Read et al., 2004; Smith, 2008). As one respondent observed, "*trying to get a job description to suit all* [Matrons] *is just a nightmare" (MM05)*. The scope and range of tasks undertaken by respondents varies in relation to the individual's role specification which determines the scope of clinical and operational management responsibilities (Table 6.1) which will now be discussed.

6.1.4 Role Specification: hybrid management

Table 6.1 illustrates the role variation across the respondents according to whether they have dual responsibility for clinical and directorate management; clinical management only; clinical management with regular, rostered clinical practice or one of the above with additional responsibilities:

Table 6.1: Variation in Matron Role Specification

	Corporate Senior Management	Dual Role Matron & Directorate Management	Matron – clinical management	Matron – clinical management and practice	Additional Responsibilities
D1	✓				
MM01				✓	
MM02				✓	
MM03		✓			
MM04				✓	
MM05			✓		✓
MM06			✓		
MM07				✓	
MM08		✓			
MM09			✓		✓
MM10		✓			
MM11				✓	✓
MM12			✓		
MM13				✓	
MM14				✓	✓
MM15			✓		
MM16			✓		

D1 holds a senior corporate management position and has overall responsibility for Modern Matrons within the Trust. MM03, MM08 and MM10 talk in terms of having dual responsibility within their designated directorate for clinical management, including leadership and professional development of staff as well as non-clinical directorate management responsibilities, for example, budgeting, resource allocation, and waiting times; these dual responsibilities are perceived to "dovetail" and are difficult to separate from each other; this "overlapping" and "blurring" of clinical and management tasks appears to work well although MM08 does comment, "*from my perspective quite a bit of that dovetails, but also quite, some of it is in opposition to each other. So that if I'm being the Directorate Manager, although I may agree with what I'm saying as a Matron, I know we can't afford it or there are other barriers in place. So there's that going on*."

This blurring of boundaries between managerial and professional responsibilities aligns with the literature on new professionalism in public management, and particularly the notion of hybrid management (Bolton, 2003; Savage & Scott, 2004). What the data shows is that managing between managerial and professional nursing responsibilities (Dopson, 2009) is a balancing act.

MM05 has clinical management responsibilities for the largest directorate (Internal Medicine) and, in addition oversees the management of five Matrons with responsibility for directorates that sit within Internal Medicine. MM09 has additional responsibilities working also as a specialist lead nurse operating at a regional and national level on cancer services.

MM05, MM06, MM12, MM15 and MM16 all talk in terms of providing clinical leadership and management within their designated directorates but are not rostered into regular clinical practice. The remaining Matrons talk of their clinical practice as an integral part of their clinical management role, with MM11 (Counsellor) and MM14 (Regional Transplant Co-ordinator) taking on additional responsibilities relating to their specific clinical practice.

The diversity across directorates in terms of what each Matron does illustrates an individualised approach to role performance,

> *The difference, which you'll find in talking to a lot of the Matrons, is that some of them have purely a Matron's responsibility but may have a bigger directorate. Some of them have a Matron's responsibility and an additional responsibility as part of that role, but in doing so may have a smaller directorate. So our roles across the Trust are very varied as Matrons. We have similar responsibilities, similar core responsibilities, but our jobs and the way we do our jobs are very different. (MM01)*

It is worth noting that the diversity in role specification within the case organisation is not an unusual finding in itself; several published evaluations on the implementation of the Modern Matron role find similar variations in role definition (Read et al., 2004; Ashman et al., 2006; Gould, 2008). However, the concept of "*being different from*" (MM01; MM04; MM07; MM09; MM11; MM13; MM14; MM15) and "*unique*" in comparison to other Matrons (MM05; MM10) is repeatedly visited as the respondents talk about their day to day work within their own directorates.

6.2 Intra-Occupational Differences: organisational structures

6.2.1 Location

The senior director speaks of the challenge being "*the size of the organisation, about how many people you've included and there are chunks of the hospital that we've missed" (D1)* and there is evidence to show that the Matrons located at the same site will work more closely with each other; this is particularly the case where the directorate specialties are related, for example, MM01 (urology) and MM04 (renal services) are physically located on the same corridor and,

> *Work extremely well together and get on extremely well and support each other extremely well. So because of that, I probably don't look to the other Matrons for that kind of help and support, and maybe if [MM01] wasn't around it would be different. I'm not saying that the links aren't there, but, you know, my strongest support probably comes from [MM01], and also from my Directorate Manager, we're a very strong team. (MM04)*

In contrast, MM09 is located at a smaller site and physically isolated from other Matrons, a perception shared across the Trust,

> *The poor [site z] are viewed a bit as the Cinderella of the Trust, because they're so far away and they miss out on a lot, and even just [Matron] coming from, from [site z] to [site x] said 'Oh God, you can tell you're the star hospital and you've got all these different services that we haven't got at [site z].' I think that's the way it's viewed across the Trust, that [site x] gets everything, the [site y] gets a lot, but [site z] gets nothing. (MM08)*

MM09 talks of her isolation from other Matrons, *"in the directorate the only key player's me (laughter)"* and how she is marginalised from the group, particularly in terms of being kept up to date and informed on things; she feels like she is "*playing catch up all the time"* with the collective Matron responsibilities, and *"didn't know that there was a policy on some things."* Other Matrons, (MM02, MM14) talk in similar terms about "*not being part of*" and being "*slightly detached from*" a core group of Matrons recognising that whilst some Matrons work closely as "*little sort of teams going around*" *(MM02)* there are others acting on the periphery.

The directorate structure also means that *"people work in little silos sometimes and there's not a lot of cross-fertilisation" (MM07)*. The analogy of organisational silos is commonly attributed to the NHS, to describe working within organisational units and professional groups rather than across them (McMurray, 2007), a point illustrated by MM02 in her description of the typical work environment,

> *Once you get into your little area as a nurse, there's nothing else happens in the universe, you know, there isn't... it was like you walked in, all these patients came in, you battened down the hatches, you done your patients and then you go home at the end of the day, and some days you didn't even know what was going on other wards. Your little area had completed its task for the day, all your patients were looked after, they went home happy and that was it.*

This highlights the relative insularity of working within the directorate structure, the result of which is a disparate group of individuals sharing the same job title but who perhaps do not know each other very well, "*some of the Matrons I have very little contact with, very little, I don't really know some of them" (MM06)* and who perceive what they do individually in their directorates to be very different from each other, *"definitely my role is very different to other Modern Matrons in the Trust" (MM04)*.

What this illustrates is relational identity construction of Matron as an individual (Alvesson et al., 2008; Ashforth and Mael, 1989; Brewer, 2001) as the perception of 'being different to' other Matrons across the organisation serves to strengthen the identification process of Matron at directorate level, through inter-relations with staff and colleagues within the directorate.

Whilst the physical location of multiple organisational sites is clearly an issue for cohesive group working, it is apparent from the respondents' talk that there are other factors which contribute to difference between individual Matrons; the way in which they have been appointed to post is a significant contributory factor to the degree to which they feel they belong to, and are involved with, the Matrons as a group.

6.2.2 Rebadged or Appointed

There is a clear distinction between the respondents in terms of how they were appointed to post and it would seem that this has a significant impact on their personal experience of the Matron role. The respondents refer to a 'first wave' and 'second wave' of recruitment to the post and there is an even spread between the group as to which applies to each individual as shown in Table 6.2:

Table 6.2: First or Second Wave Recruitment to Post

1st Wave: "Re-badged"	2nd Wave: Appointed
MM03	MM01
MM07	MM02
MM08	MM04
MM09	MM05
MM10	MM06
MM11	MM14
MM12	MM15
MM13	MM16

6.2.2.1 Rebadged

The 'first wave' describes initial appointments to the Modern Matron title through a "rebadging process" whereby senior nurse or Assistant Directorate Manager positions within directorates were re-titled as Modern Matron,

> *Then suddenly the Government said we needed to have Matrons, so the way we as an organisation approached it was if people who were in positions that would be an ideal Matron type role, one minute you came to work and the next minute you were a Matron, just rebadged roles. (MM01)*

The implication here is that rather than being a newly created post, with different responsibilities, the Modern Matron role has been "*an add on to my job…although lots of it seemed a natural progression, it wasn't brand new...so it wasn't a massive change" (MM11)* and that *"there were very few jobs appeared that were actually created as a result of this" (MM03).*

This differs from the political rhetoric of Modern Matron as a new position introduced to bring about changes to practice; the implication is that much was already in existence, "*I'm not saying that all of a sudden Matrons came along and they made it happen, I think there was all this going on before" (MM02)* and *"certainly the patients' responses*

from when they changed the title has been so positive, it's quite funny. They go "Oh you're back" and, you know, you've never been away (laughs)" (MM13). Similarly, MM03 muses on the difference since taking on the Matron title, *"whether I've actually changed since I've become a Matron, I think that's come into question….I think when I was Assistant Specialty Manager I did a lot of these things in any case."* MM07 tells a similar story, *"now originally this was a senior clinical nurse post, so it was rebadged as a Matron job. So I ended up doing everything that I did before plus all of the Matron parts for [specialty]."*

The rebadged individuals place great emphasis on how they maintain all aspects of their previous role in addition to embracing the Modern Matron title and its corporate associations, in effect, they are Matrons through a title change rather than by a significant change between what they do as Matron in comparison to what they did before.

6.2.2.2 Appointed

Other respondents talk about being part of a "second wave" of appointments to the post of Modern Matron; in these cases, all applied for a newly created post of Modern Matron, in directorates where rebadging had not occurred. The experiences of 'second wave' recruits are significantly different in that none have dual clinical and directorate management responsibility and in most cases, the appointment offered career progression; four respondents specifically applied for the position as promotion from ward sister (MM01, MM02, MM14) and nurse practitioner (MM04) posts; three respondents (MM06, MM15, MM16) were external candidates, applying to join the Trust as Modern Matron, as a chosen career option; two of these individuals had previously worked at the Trust and wished to return to the organisation. One appointment (MM05) occurred during the first wave, however, this particular Matron post was specifically created to oversee the largest directorate within the organisation and provide line management for five Matrons operating at specialty level within it.

The 'second wave' appointees regard the Matron role to be a change from their previously held posts, unlike the 'first wave' respondents, which might be a result of

actively choosing to apply for it. The appeal of the role is that the policy rhetoric of what the Modern Matron should be aligns with their own personal values, *"I wanted to do it, it was a strong pull towards looking at basic care" (MM02)* and "*being involved with staff, clinicians and patients…I think it's important to support staff" (MM04).* The 'second wave' Matrons embrace the reintroduction of the Modern Matron responsibilities as correctly belonging to professional practice of nursing and take ownership and accountability for this, 'colonising' the role as their professional right (Dent et al., 2004).

6.2.3 'Part of' or 'Peripheral to' the Collective Group

The differentiation between first and second wave Matrons is particularly prevalent in the observations the respondents make about one another, here MM01, appointed to post describes the rebadged Matrons,

> *All of a sudden they were this group of Matrons who developed quite a strong core. They went off and did the Leo Programme* [7] *together and used that as a bonding exercise. I think that probably worked very effectively for them and, as I say, it's not any of them saying 'we're not welcoming you Matrons to our group' type of thing, it's not that in the least, but that's a very strong group and the rest of us sort of feed into that group, and in some ways it's up to yourself to do something about impacting on that group. I think they're probably a stronger peer group than the rest of us are. (MM01)*

There is a noticeable differentiation between the "*original group of Matrons who started off*" and "*other Matrons who have sort of joined in after that" (MM08)* with general acknowledgement that the first wave of Matrons "*were very much established as a group*" *(MM04)*, partly as a result of attending the NHS leadership programme (LEO)

[7] The Leading an Empowered Organisation (LEO) training programme is a government led initiative aimed at strengthening and improving leadership within the NHS (Source: Trust website), and indicative of the managerialist ideology influencing the reform agenda in the NHS (Sanders, 2002)

together which "*gelled us together as a group*" (*MM12)*. For second wave Matrons who have taken up their posts later, integrating into *"the Matron... inner sanctum, if you like" (MM09)* has its challenges. There is a sense of being on the periphery of the Matron group, *"being isolated" (MM06)*, "*feeling different from them" (MM04)* and not "*feeling part of it" (MM14)* whilst also not having *"the close contact that other people do" (MM02)*.

This difference between being part of the core group or peripheral to it is corroborated by their identification of immediate peers; first wave Matrons unanimously identify "other Matrons" to be their immediate peer group, with a few (MM03, MM08, MM09, MM11) also specifying colleagues in their directorates as parallel peer support. Meanwhile, the second wave Matrons all refer to their directorate colleagues as their primary peer support, placing high value on shared knowledge and expertise within the specialty teams. Only MM02, MM05 and MM16 specify the Matron group as secondary peer support.

Building relationships with other Matrons and becoming a member of the group is important, "*I'm new and I'm just starting to get to know everybody" (MM15)* but the directorate structure can be restrictive to opportunities to meet and build relations with other Matrons dispersed across the Trust resulting in a reliance on a small number of individuals for support and help rather that the group as a whole, a point corroborated by MM09 who comments, "*it would be a small group of people who were particularly helpful when I first came in to post from a Matron perspective."* Amongst the respondents, MM15 is the newest Matron in post and she tells of her experience,

> *So I'm gradually going to get to know these people and build up relationships, for instance, I rang [MM10], because I know her, only because I dealt with her before when I was a ward sister. So I'd met her and I knew her and I felt ooh, now she's a Matron, she's on the same level, she's done this, I know her so I can go to her and I feel as though I have got a lot of support from her. (MM15)*

Findings by Ashman et al. (2006) suggest that Matrons can be particularly effective in their role when acting as a group. The different ways by which our respondents came

into post and their subsequent identification as 'insider' or 'outsider' to a core group of Matrons suggest there is no cohesive group identity (Horton, 2006) and that social identification is more likely to be founded on person-based relational interactions between those they work with most closely, at directorate level (Brewer, 2001; Halford & Leonard, 1999).

6.3 Managing Tension between Managerial and Professional Discourse

It can be argued that the variation in role specification (Table 6.1, p. 118) is illustrative of positions along the professional-managerial continuum (Causer & Exworthy, 1999); Matrons are managing professionals, within which some are the practising managing professionals and some are non-practising managing professionals. The complexity of the role lies within the extent to which the individuals "retain a measure of identification with the professional group" (ibid. p.85) or succumb to a managerial identity.

It is through the individual performances of Matrons within their directorates that the "contested terrain" (Edwards, 1979) between Matron as manager and Matron as professional nurse is played out, *"it's almost as if there are sort of like two different types of Matrons, those that are strictly a nurse in like leadership and doing Matron role things and those that have like got an, an extreme managerial component as well" (MM03).* As seen previously (Table 6.1, p.118), for some Matrons, clinical practice is an integral part of the role but not for others and it would appear that involvement in clinical practice is a significant contributory factor towards their self identity.

The respondents have had to find ways to reconcile the diversity of managerial and clinically based tasks within their day-to-day practice. For example, MM13 whilst "*loving the clinical side*" had also enjoyed "*a taster of the management side"* and whilst not wanting to be doing management "*every day, all day"* found that the Matron role "*looked like you got the best of both worlds."*

Those respondents for whom clinical practice is an integral part of their role speak of it as something from which they derive great satisfaction, *"I love the clinical side of my job" (MM13)* and "*the things that I enjoy most, I would say, would be the opportunity to still maintain clinical input" (MM02)*. Being part of the team, "*rostered as part of the*

numbers" (MM01) enables the Matrons to "*see the problems that they have"* and thus understand and be a better advocate for them, illustrating the importance of relationship-building to their clinical leadership role (Millward & Bryant, 2005) perhaps indicative of a feminized management style, participative, interactional and relational (Fondas, 1997) but also illustrative of the congruence between role and personal values in the social identification process (Hewison, 1999).

Meanwhile, those respondents who do not undertake regular, rostered clinical practice, usually because of managerial demands on their time, show regret not having a clinical workload: "*I desperately wanted the job to be more clinical than it is" (MM06); "it's an area of my role that I miss" (MM08)* and is "*not as big an element as I would like" (MM05)*. In these cases, the respondents continue to explain themselves further, offering justifications for why this may be the case, *"because it's such a huge area I find that my clinical time is really quite limited, it's very difficult to find the time to actually go and work a shift on the wards" (MM06)* and "*I try and roster myself in to have clinical input, but it's difficult because it just takes one thing to trigger off and I'm pulled away"(MM12)*. What contribution they do make tends to be prompted by staffing shortages, "*last month they were desperately short of staff so I did two full days" (MM09)* and is often "*a bit ad hoc, but that's got to change, I've got to get that organised. It's just because of the way things have been at the moment" (MM15)*.

For those Matrons who have little or no clinical workload, they refer to clinical management such as policy work and monitoring standards as equally relevant and legitimate nursing work. The respondents talk in broad terms about clinical practice as encompassing more than "hands on" care, that "*there is a little bit more to it and you don't have to be at the bedside a hundred percent of the time to feel that when you go home of a night time you've done your remit" (MM02)* with the emphasis that "*it isn't just about making a bed or washing someone. It's about all the knowledge and skills that go into talking to that patient, talking about the disease process and all the treatments that go into it" (MM14)*. This is reflective of the contemporary, professionalised nurse; taking occupational control in the endeavour to show nursing is more than vocational care-giving (Macleod-Clark et al., 1997; Salvage, 1998).

For some, it is important to justify their lack of clinical practice which MM02 suggests is because "*there's a guilt thing there with nurses where if you're not doing the very, very basics then you're not really nursing."* Meanwhile, MM09 elucidates that "*there's still almost a feeling that you need to justify what you do, I think that's a problem in nursing generally*." This is illustrated by one respondent, who differentiates between being "purely" Matron and being Matron with extra managerial responsibilities, justifying her position but ending with a note of resigned acceptance,

> *I'm always keen to tell people that I am an Assistant Directorate Manager as well, I think it's important because I think that's what stops me I think from being able to work as clinically as some of my purely Matron colleagues… This is the role I have, I'm an Assistant Directorate Manager and it's not always going to be possible for me to work on the wards clinically, that's just the role I have and that's what I have to accept really. (MM08)*

The desire to explain to others why she is not able to work clinically is indicative that this particular respondent does not feel comfortable with the overtly managerial aspects of the role and the tension between professional/manager is clearly visible.

This inherent guilt and tension between the professional and managerial aspects of senior nursing roles are encapsulated by D1 who talks about not having "*worked on a ward for sixteen years, since I was a proper nurse."* This however she promptly justifies through the discourse of patient-focused care for which she has ultimate corporate responsibility, "*that's why I'm here, that's what my job's all about, and that's how I rationale if I'm having a bad day with all the paper, because it's made a difference to what happens on the wards and that's what the whole service is about*" *(D1).*

The feelings of guilt and regret and the need to justify distance from hands-on nursing is indicative of the "continued strength of an "old professional identity" (Halford & Leonard, 1999, p.110) within themselves. It is clear that, despite the variations in the clinical involvement of each individual respondent, clinical practice will always take priority over other tasks, "*if somebody's bleeding out, you just don't go for the meeting, you just get hands on, do the medicines, do the IVs, to help the staff out there" (MM05)*

and "*in an emergency you drop what you're doing and you go back to the clinical environment" (MM11)* because the role is about nursing, first and foremost and "*it'll always be the clinical side that has to come first…that always takes priority…everything else has to go on the back-burner for a little bit" (MM13).*

There is a broad preference for clinical practice over managerial work and having time to be able to be involved with "hands on" nursing is something they do not wish to lose. MM03 talks of, "*first and foremost being a nurse as opposed to being a manager"* and reveals his own concerns at being regarded as management rather than nurse, *"I think there are some very strong prejudices about management staff and people referring to the management within the hospital and I didn't know whether I was part of the management or still seen as a nurse" (MM03).*

6.3.1 Prioritising Clinical Care over Corporate Responsibilities

Clinical involvement, whether this be involvement with *"clinical issues and policies and procedures and standards of care" (MM16)* or *"bed-bathing a patient on one of the wards" (MM02)* is positively favoured above more corporate, policy based managerial tasks of the role. MM09, when asked what appealed most about the role reflected "*it was probably less the Matron bit and more the clinical nursing, associate lead nurse bit. I don't know that I would have applied for a Matron job" (MM09).* MM09 maintains a clear division between her two roles as Matron and speciality lead nurse and it is clear that she perceives the Matron to be a managerial post. MM16 makes it clear that she "*doesn't touch*" any directorate management tasks. Similarly, MM01 recalls her reaction when asked to consider applying for the Directorate Manager's job,

> *Hell would have to freeze over before I would do something like that; it's not where my skills lie. I don't have good business management skills, that is not the thing that I'm good at. (MM01)*

As shown in the literature (Section 3.3.4, p. 59), altruistic care is a deep-seated nursing value (Taylor, 1997; White, 2002) and is something to which all the respondents refer;

this speaks to identity located within the individual's concept of self (Brewer, 2001). The appeal of the Matron role to respondents is that it is firmly positioned within the clinical domain; they are clinical leaders, not business managers. The clinical leadership aspect of the role, focusing on "facilitating evidence based practice and improved patient outcomes through local care" (Millward & Bryan, 2005, p.xv) is congruent with their personal, deep-rooted values (Hewison, 1999), in this case, the ideology of vocational care which is fundamental to nursing philosophy (Keogh, 1997). Meanwhile, the managerial, business-like aspects of the role, such as attendance at corporate level meetings, managing budgets and implementing policy, are placed as secondary to clinical priorities. The prioritisation of clinical over managerial issues illustrates the contradictory nature of the hybrid management role; the Matrons respond to the competing tasks in relation to clinical directorate needs, rather than corporate directives. This is the Matrons' "backstage" performing within their clinical domains, their actions and interactions governed by their personally held beliefs and values (Goffman, 1990).

The data shows that the respondents have a very strong attachment to the directorate for which they are Matron*, "first and foremost I'm the Matron of the department" (MM14)* and this loyalty to the clinical specialty and directorate team appears to supersede broader role allegiances across the organisation. MM03 speaks with emotion about how his "*heart lies with the directorate*" and that he is "*ferociously loyal to my staff."* Meanwhile, MM02 explains, "*I think the way I view it is I work for the Trust and there are corporate things that need to be done, but my key role is probably the directorate, and whatever needs to be done within that directorate at that time is what I will be doing*." MM09, a Matron with additional responsibility as specialty lead nurse at regional and national level talks of putting the clinical specialty above all else, "*not just for this directorate but for the Trust as a whole, that's my big priority" (MM09).* These issues of difference and prioritisation according to specific needs of the clinical directorate are 'played out' as the Matrons implement policy directives; the case in point here is Essence of Care.

For the Matrons, Essence of Care presents an opportunity to take the lead on and get involved with issues of clinical practice. The policy initiative is founded upon basic

principles of nursing care, a professional ideology to which they subscribe and the principles of Essence of Care are positively received by the respondents (Hewison, 1999). However, it is essentially a managerialist device to monitor and manage professional practice in relation to quality of care provision. Currie et al. (2009) observe that other nurses may feel that the role of Modern Matron risks undermining their professional credibility with the result that “those within their own ranks of nursing may seek to manage Modern Matrons in a way that limits their influence” (ibid. p.298); this supports espoused theory that managerialism threatens professionalism (Dopson, 2009; Sehested, 2002). The complexity and disparate nature of the Matron role is reflected through the implementation of Essence of Care within individual directorates.

6.4 Essence of Care: differently interpreted; individually led

Within the directorates, there is wide variation on the extent to which Essence of Care has been embraced by both Matrons and staff,

> *The majority of Matrons on the Essence of Care steering group are very much committed to it, and can see the benefit and are enthusiastic about it and that makes it easier. There are some that you feel like you’re dragging along by the skin of their teeth, you can tell when you send things out for comment or response, I can tell you who’s going to respond and which ones I’m going to have to chase, and which ones are never going to respond. (D1)*

Of the twenty three Matrons who were in post at the time of this research, seven did not respond to the invitation to participate; it is not possible to know why this may be but, it was inferred by a couple of respondents that some Matrons were not as participative as others[8]. With regard to the sixteen Matrons who were interviewed, there is variation in the degree to which they, and their directorates, have been involved with Essence of Care as illustrated in Table 6.3:

[8] Personal Notes

Table 6.3: Respondents' Involvement with Essence of Care

	Essence of Care Steering Group	Lead Matron	Facilitation within directorate	Little or no involvement
MM01	✓	Continence		
MM02	✓	Nutrition		
MM03	✓	Record Keeping		
MM04			✓	
MM05	✓	Safety & Risk		
MM06				✓
MM07			✓	
MM08			✓	
MM09				✓
MM10	✓	Self Care		
MM11	✓	Privacy & Dignity		
MM12	✓	Nutrition		
MM13			✓	
MM14			✓	
MM15				✓
MM16			✓	
D1	✓	Chairperson		

MM08 explains the variation in involvement with Essence of Care as,

> *Everywhere was doing it differently, and some weren't doing it at all, we were all in a way looking under the microscope at our own directorates. (MM08)*

There are seven Matrons (MM01, MM02, MM03, MM05, MM10, MM11, MM12) who talk of regular participation in the Essence of Care steering group as Lead Matrons for the aspects of care that were being implemented at the time. D1 chairs the group. MM12 is identified by MM05 and by MM12 herself as the driving force behind the organisational process for implementing Essence of Care drawing from past experience

with writing and auditing standards and who *"took the idea to D1 who thought it was great and we could manage it like this; the first one we tackled was nutrition. MM02 was the chair of the group and I joined her on the group" (MM12).* This explains why there are two leads for the nutrition standard. MM12 very much appears to take an advisory role on the Steering Group based on her previous experience with benchmarking.

MM06, MM09 and MM15 have little or no involvement with Essence of Care citing being new to post as the reason for a lack of involvement with both the Steering Group activities and facilitating Essence of Care within their own directorates. MM06 describes how she felt when first tasked with implementing Essence of Care,

> *I didn't have any training (laughs) with coming in after it had started, it was more or less just thrust under my nose and said, here, this is what you do, you get on with it and that's that. And so it was a bit difficult. I didn't quite understand it and wasn't sure how it worked, and being new in post it was very difficult, this was just something else, you know, all caving in on top of us, and it took us a good while to really get to grips with it. (MM06)*

Meanwhile, MM15 is new to post and describes her involvement with Essence of Care following from her predecessor who had been the Lead Matron for Personal and Oral Hygiene, *"so the first thing I was given when I started this was to write up the Trust's response (laughs) for personal and oral hygiene. So you can imagine I was horrified, because I'd had nothing to do with it…so I've had myself in a bit of a pickle with that."* Having completed the report, she goes on to explain,

> *I've set up monthly meetings from now on, so that we can get back into the swing of things. The first few meetings are going to be for me to familiarise myself with what they've been doing but that's as far as I've got, and I have to be honest, because the other things that I get involved with here are major... just fire-fighting issues on a daily basis. (MM15)*

For MM09, also relatively new to post, Essence of Care is low priority for the directorate, a regional specialty unit and with competing political and time demands,

> *I think another time Essence of Care here could have been embraced much more, but with the other political drivers at the moment, they have to take priority. I wonder whether Essence of Care would have been given a different slant if we'd had the time to give to it. We've already got audits and things ongoing within our directorate that's different to a lot of other directorates…so if you've got all of the other things that people are asking you to do, Essence of Care becomes a small amount of it. (MM09)*

For the other respondents, they contribute to Essence of Care work within their directorates, facilitating the benchmarking on ward level, collating the results and feeding that back to the Lead Matron for each aspect of care. The extent to which other staff in individual directorates are involved varies,

> *The individual Matron in that clinical area will roll it out within their own directorate in the way that they've decided to do, and that's where you get some variation in how the benchmarking actually goes on and whose involved in the groups at a local level, who leads on it at a local level but the end result is still the same. (MM10)*

The variation of activity levels on Essence of Care within individual directorates seems to be dependent on the nature of the specialty in terms of the appropriateness of: i) the benchmarking standards to the clinical practice and ii) the extent to which staff get on board with the initiative.

6.4.1 Adaptation

Non-ward based departments including outpatient clinics and Accident and Emergency "*have struggled with Essence of Care in certain aspects of it*" because some of the

aspects of care, for example, pressure ulcer care, are more suited to long-term ward based hospital stays meaning that "*some of it wasn't relevant and you just had to interpret that to your department*" *(MM11).* That said, the non-ward based directorates have worked creatively with the benchmark standards to apply them to their specific settings, for example, in relation to nutrition, introducing snack boxes for outpatient clinics and Accident and Emergency (MM07; MM08; MM13) and, again in Accident and Emergency, *"the ones that we have done have been really useful, certainly the privacy and dignity we came out really well because we have a lot of cubicles..and the staff are very aware of the importance of it" (MM13).* For Matrons working in non-ward based clinical areas, they have had to think more creatively around Essence of Care and be more selective in what can be applied to the clinical setting, again indicative of the experimental approach to implementation (Matland, 1995).

6.4.2 Leading Change

The second differentiating factor between the directorates is the extent to which other staff are involved with the benchmarking process. Here, the role of Matron leading others, being able to influence and encourage participation comes under scrutiny. These skills are integral to the success of clinical leadership (Ham, 2003) but are difficult to achieve in practice (Millward & Bryan, 2005, p.xvi). A major challenge has been for the Matrons to influence professionals from other disciplines such as medical colleagues, allied health professionals and health care assistants, *"people outside of the nursing profession were far from enthusiastic" (MM05)* and "*weren't keen to be part of it really" (MM01).* There is a general perception that it has been universally difficult to engage with other disciplines, except for MM14 who talks of very positive relations between different staff groups in the directorate, although even she comments,

> *We set about all different grades of nurses, social workers, doctors even, doing things. They enjoyed doing some of it. They didn't enjoy some of the other areas, they thought it was very tedious and didn't apply to them. (MM14)*

MM11 described trying to engage midwives with Essence of Care; however, not having management responsibility for the midwives was problematic in requesting their involvement and co-operation,

> *Some of our principles of what we think are important differ in practice and they don't always come to all the nursing groups that's happening in the Trust. So I was then coming back to them as a group of midwives and saying "Right, this is what we're doing with Essence of Care, you need to be involved with this as well. It has implications for your practice… they couldn't see it…and they laughed about it and it was a huge joke…it wasn't a very nice experience for me. (MM11)*

One of the challenges of the Modern Matron role is working across occupational boundaries; here it is evident that the Matrons do not have the requisite authority over their colleagues in medicine and allied professions to engage them with Essence of Care. It is indicative of the strength of the medical hegemony within which the Matrons work and their heteronomy (Dent, 2003) which constrains them in performing their work. An example of the difficulties in engaging medics is given by MM08 who explains "*medical audit, that's all they see as important, mortality and morbidity outcomes"* but Essence of Care *"is not about that, it's about, about the basics"*, the implication being that medics do not concern themselves with the basics of care (McMurray, 2010). This issue is discussed further in Chapter 7.

The staff group that engage most with Essence of Care is nursing, "*it's very much run and owned by nurses in this Trust, despite many attempts to engage with other health care professionals" (MM10)* with evidence that all levels of nursing staff have been encouraged to be involved to a greater or lesser degree although when asked about frontline staff involvement, MM06 replied, *"a bit mixed I think, some wards are much more thorough than others, and it depends which member of staff does it" (MM06)*. Most activity tends to have *"been done by staff nurses" (MM02)* and the Matrons themselves, *"it fell mainly on me" (MM11)* and *"I've implemented largely on my own and relied on the feedback" (MM16)*.

6.5 Concluding Thoughts

The picture emerging from the respondents is one of highly individualised action, about working at directorate level, motivated by personal values and beliefs, deep-rooted in an ideological discourse of "care" (Hewison, 1999; Keogh, 1997; Sluss & Ashforth, 2007). The ways in which respondents have come into post influence the extent to which they perform as practising professional-managers or non practising professional-managers (Causer & Exworthy, 1999) and this seems to create a tension between those Matrons doing "proper" nursing (hands-on, bedside care) and those who wish to be closer to their clinical roots but are constrained by managerial responsibilities. The Matrons display a deep loyalty to clinical practice and the 'guilt' they display when removed from this aligns with the notion of clinical management as "deviant" as it creates a distance between nurse and patient (Taylor and Hawley, 2010) whilst also indicating the deeply held ties to their professional identity (Halford & Leonard, 1999).

As the respondents perform the Matron role, a discourse of professionalism prevails through which they discursively construct their self identity as nurse, influenced by their emotive responses to the clinical/managerial divide, feelings of guilt, regret and frustration (Halford & Leonard, 1999). Here the Matron role is an individual performance, reflecting deeply held beliefs and values about what it means to be "*a nurse first and foremost*" *(MM03)*. It is their involvement in clinical work, focusing on the patient and support for principles of basic care that motivates them in their work, "*the patient is at the end of whatever you do, regardless if you're a Matron or the health care assistant or the domestic, the end is the patient, and delivering the best care for that" (MM14)* because "*that's what we're all here for isn't it, better patient care" (MM12)*.

Similarities and differences are articulated through organisational structures, policy discourse and through inter-relations with others; an ongoing reciprocal interaction between the system vs. individual; structure vs. process; macro vs. micro levels of organisation (Sluss & Ashforth, 2007). The data suggests that the Matrons work in different spaces, across all levels within the organisation, this "boundary spanning" (Ainsworth et al., 2009; Sveningsson & Alvesson, 2003) has significance in the way the role is defined and performed, in particular, through role relationships.

It has been suggested that relational identity, the formation of identity through interdependencies between roles in the workplace, has usefulness in understanding the changing nature of professionals and their work and that relational identity is underexplored in organisational research (Brewer & Gardner, 1996; Sluss & Ashforth, 2007). MM05 talks about the role being formed through inter-relations with others; the implication here is that what others "*get out of the Matron role"* contributes to role definition. In addition to their responsibilities to the Trust Board, the respondents speak of being responsible for, and accountable to, patients and staff. The way the Matrons talk about the interactions between themselves, their staff and patients, illustrates relational identity (Sluss & Ashforth, 2007), a dynamic account of role construction, across different organisational boundaries..

The following chapter explores relational identity further, focusing on how the role of Modern Matron is enacted through complex inter-relations with others organisationally situated above, beside, below and beyond the Modern Matron. These "others" include, as has been discussed in this chapter, the Modern Matrons themselves but also, nursing subordinates, medical staff, and patients. The relationships between these groups are enacted through performances of power, authority and autonomy deriving from competing discourses of professionalism, managerialism and care.

7 MODERN MATRON: AN AUTHORITATIVE ACT?

This chapter explores role relationships and their significance to the relational identity construction of the Modern Matron as discursively acted through power and authority: first, I consider the interaction between the Matrons as clinical leaders and subordinate staff; second, I explore the inter-relational aspects of the role as performed across occupational boundaries; third, I consider the interactions between Matrons and their patients. The remit of the Modern Matron to provide clinical leadership in support of others and be a visible presence on the ward are premised on an assumption of authority implicit within the role. Authority is gained through status and credibility and is integral to professional identity (Evetts, 2005; Freidson, 2001). Whilst the traditional image of Matron projects undisputed authority through command and control leadership (Bufton, 2005), this is not necessarily experience of Modern Matron in contemporary nursing management (Currie et al., 2010).

7.1 Clinical Leadership: working with subordinates

A key aspect of the Modern Matron role as written in policy, is to provide clinical leadership to frontline staff (Section 3.4.1, p.63); as has already been established (Figure 5.1, p.92), the respondents are all senior nurses with significant nursing knowledge and experience; it is this that gives credibility and legitimizes them as clinical leads. In their discussion of clinical leadership, Millward & Bryan (2005) refer to the "complex process of interpretation and translation" (ibid. p.xvii) at the interface between the clinical leader and those being led, suggesting that it is a "delicate balancing act" (ibid. p.xvi) between making clinical judgments, translating policy, being politically astute and cognizant of constraints, realities and the perspectives of others; clinical leadership as relationship management.

Credibility as a nursing professional enhances clinical authority and autonomy to flourish (Dent & Barry, 2004) adding to the Matrons "personal power" (Read et al., 2004). The data reflects the high value that respondents place on being credible and respected by staff in their individual clinical directorates.

Within their own directorates, the Matrons perform in line with the definition of occupational professionalism (Evetts, 2005) in that they exert power, authority and autonomy based upon their performance as professional nurses; for example, length of service, "*I'd worked in the department for a lot of years so was very well known within the department" (MM01)*; knowledge of clinical practice, "*I've worked in every area which has helped me because I can hand on heart say I know how every area works because I've done it over the years" (MM04)* and "*they see me working in practice, so they don't feel that I'm detached from what they're actually doing, and I'm clinically responsible" (MM14);* and demonstrable experience, "*I think it's important for them [staff] to be able to look to you as a clinical role model, you do have accumulated skills and knowledge" (MM10)* all of which serve to legitimise their authority and confer respect and autonomy,

> *I'm fortunate because I've always worked here, people know me, and I'm quite well respected. So if I go out and say I need to do this because or I want to do this because, nobody's really stopped me. (MM11)*

The language of 'being known,' 'trusted' and 'respected' enhances their identity as a credible nursing professional from which they can draw individually held power and authority in performing their role (Ainsworth and Hardy, 2004).

Policy documentation (DH, 2001b) advises that the Modern Matron role should provide support to ward sister/charge nurse level and it would appear from the data that this is indeed how the role has been interpreted and is being performed within the case organisation; Matron is "*a clinical role model" (MM10)* for junior staff and, as the Matron for Accident and Emergency described, "*in some respects we become like their parents because some bring everything to you…it's really important to be able to support them, because especially in A & E, it's extremely stressful."*

This support involves "*offering advice"(MM03)* on clinical matters, staff development and career issues; teaching on practical issues, "*if a junior nurse can't put a catheter in you'll put your pinny on, you'll put your gloves on, you'll do a teaching session and show her what she's doing wrong and what can be done different" (MM02)*; guiding and supporting individuals to develop in the role, "*enabling the ward sisters, helping them to*

develop…we had a number of junior sisters just coming into post and it's seeing the way they've developed…they very much needed a lot of support and guidance in the beginning" (MM08) whilst also managing inexperienced staff and the problems this can create, "*I've got quite a lot of sort of inexperienced G grades…since I came into post there's been quite a lot of strife…there's been a lot to sort out" (MM06)*; and being an advocate for the ward sisters (Grade G).

MM13's 'parent' role, the instructive mentoring by MM02 and the caring guidance of MM08 all serve to illustrate the highly personalized nature of the relations with others; the Matrons give emotionally to the role, subjectively engaging with relational role construction, corresponding to those they help to support (Sluss & Ashforth, 2007). This is further exemplified when the Matrons emphasize the importance of being approachable and accessible to staff both physically, "*I've got an open door" (MM02, MM10)* and in terms of their personal understanding of the job based on their own clinical knowledge and direct experience, "*it's perfect that I do get to work with the staff. I see the problems that they have and I think that informs me better when I have to represent them at management meetings. I know where they're coming from and I can marry the two much easier than if I was completely devoid of clinical responsibility" (MM13).*

Some respondents positively embrace the personalized nature of the role relationships formed through interaction with others, *"I see my role very much as supporting the ward sisters in their role… to be there as a support when they need…" (MM08)* and *"if I wasn't around they wouldn't particularly have anybody to turn to, and it's a tough role being a ward manager and I think they need somebody" (MM06)*. This emotional commitment to care for staff welfare is also evident in comments about support for non-nursing staff, in particular, junior medics "*a lot of the problem is that people are scared as junior doctors, the people who have just been Housemen, they'll go on to be Senior House Officers, are really spooked, they need the support because they get scared" (MM07).* Here we see evidence of Matron working across occupational boundaries, taking an authoritative role in advising and guiding more junior staff. Of interest here is the positioning of Matron as above the junior medics; it appears somewhat anomalous to the overt medical hierarchy in which nurses are subordinated (Dent, 2003; Crawford et

al., 2008; Hallam, 2000) for a nurse to be giving guidance and support to a medic but this is perhaps indicative of the professional authority Matron has as a senior nurse with significant experience and technical proficiency from which the junior medic can learn. It is also noticeable that MM07 is responding to the emotional needs of the junior medics, epitomizing the "support work" (McMurray, 2010) that nurses provide for medics.

Similarly, the Matrons offer support to non-clinical managers, "*our Directorate Manager's not a nurse so because most of the workforce is nurses, a lot of things she would come to me with although she would be managerially responsible for them all, she tends to come to me for advice a lot" (MM09)*. Again, Matron is working across occupational boundaries, giving help and guidance to senior management. Here Matron is positioned as equal to her colleague, with professional status conferred through specific clinical knowledge that she can impart.

Knowledge and experience plays a big part in legitimising the role that the Matron has to provide support, guidance and advice. This also gives credence to the role as a corporate position, with legitimate authority and influence, as one respondent puts it, "*the knowledge that we've got is underpinned by our clinical experience, we're good facilitators" (MM11)*.

There is a clear sense that using clinical knowledge and experience to help support others is a satisfying element of the role; their professional credentials, superior knowledge and experience confirm the Matrons' status as a senior authoritative professional (Freidson, 2001) and has resonance with the traditional image of Matron as presented in policy rhetoric. The respondents embrace this archetypal image, and by doing so, align themselves with professional and managerial discourses of masculinised authority (Whitehead, 2003).

However, whilst the "*coercive power*" of old style Matron is acknowledged, there is a general sense that "*throwing your weight around*" and "*barking orders at people" (MM07)* is not an effective way to manage and work with others; rather a good working relationship "*has to develop with other members of staff as they see what you do and what influence you have and how you can benefit them and the organisation and the*

patients" (MM05). This describes transformational leadership, emphasizing interpersonal skills to motivate, influence and inspire others (Millward & Bryan, 2005) as reflected in the policy rhetoric of the Department of Health's leadership (LEO) programme which the first-wave Matrons had attended; this shift towards more influential management can be argued to reflect a more feminized approach to managing (Fondas, 1997; Whitehead, 2003) and is more concomitant with ideological nursing values of care. The data shows the Matrons draw from two 'opposing' managerial styles as need arises, characterizing the boundary spanning role that they perform.

7.1.1 'All and Everything': contradiction in role

The respondents comment that the clinical leadership they provide is positively received by staff, "*the feedback I've had has been very, very positive" (MM06)* and "*I do get positive feedback from the staff that they do appreciate it" (MM13)*. Being visible and responsive to staff helps to define the Matron as a point of contact, "*a new person that they could contact and get everything done quickly" (MM13)* thus affirming the Matron role in relation to the policy rhetoric of Matron as problem-solver but, it also presents challenges, *"often it works to me detriment because I think if you go looking for problems you'll find more than you want" (MM03)*. On the one hand, the respondents espouse traditional Matron and yet on the other, they perform tasks which serve to undermine this authority.

The 'problem' is in managing the expectations of others with regard to the extent of the Matrons' remit to be responsive and provide 'support'. There is a perception that "*Matron is all and everything" (MM13)*, and *"a Jack of all Trades, and a Master of None" (MM15)*; a trouble-shooting support role, a "*ghostbuster*" *(MM06)* who will sort out problems picking up tasks and responsibilities that others should and could do, "*you do get a lot of problems dumped on your doorstep" (MM01)* and "*it's always the Matrons things are given to…that's the nature of your role" (MM14)*.

There is some disquiet amongst the respondents that the Matron role should not always be relied upon to sort out all issues that arise, particularly as *"there are other people who could have sorted it"* and that, for example, seeing "*how many headsets there were on*

the wards for the radios" is perhaps not "*what we're here for" (MM13)*. Whilst recognising that junior staff have less experience to cope with some tasks, there is frustration that "*sometimes that inexperience means my bleep goes off for things that, [when I was a G grade], I'd have probably handled myself" (MM15)*. The Matrons have to manage a *"very fine balance" (MM01)* between offering support by doing for others and supporting others to do for themselves, *"a difficult balance to strike sometimes" (MM01),* a point echoed here,

> *I have to be careful that I don't take on things that really some of the sisters should be sorting out themselves…I'm starting to think now hold on, I'm not going to sort this out for you and I think you can do that, and yes I'll support you but, as a G grade I think you should be doing that. So I'm very conscious of that now at the moment, because otherwise I'll just get burnt out. (MM06)*

There are two interpretations to be made from this; the willingness of the Matrons to fulfil their role in supporting staff highlights the subjectivity and emotional commitment that the Matrons have to others and speaks to the high degree of personalization that occurs in social identification through role-relationships. It is argued that this degree of personal involvement is needed to bring stability to turbulent organisational settings (Sluss & Ashforth, 2007). However, it could also suggest that their authority is being undermined by other nursing staff who "may seek to manage Modern Matrons in a way that limits their influence" (Currie et al, 2009, p.298) in the clinical domain; by not doing certain tasks (for example, an equipment audit) nursing staff reject managerialist attempts to control their workplace; as Matron steps in to fulfil the task, she/he reinforces her/himself as manager over nurse and highlights the contradictions implicit within the professional-manager role. A limitation in my research is that the data does not consider alternative views from other nursing staff by which to support or refute this suggestion.

7.2 Working with other occupations: a different type of authority

Political rhetoric and espoused theory of traditional Matron suggest the Modern Matron role is imbued with unquestionable power and authority across the organisation but the reality as described by the respondents reflects a much more ambiguous and negotiated position. The respondents can command authority through clinical leadership of subordinate nurses however, this is not necessarily the case when working across occupational boundaries, and in particular, when considering the overarching medical hegemony within which nursing sits. It is inter-occupational power relations that reveal identity as negotiated, fluid and contextual (Alvesson et al., 2008).

At times, the Matrons exert a different type of authority based on leading by example, by being known, trusted and a visible presence; helping others in order to build good relationships, one respondent tells of helping a porter with the result that *"now he'll do anything for me" (MM06)*. In particular, the need to gain credibility with medical colleagues emerges as one respondent recalls helping resolve a problem for a consultant *"and it was like you'd handed him a pot of gold, and suddenly there I was, useful" (MM05)*.

7.2.1 Working with Medical Colleagues

In general, it appears as though the respondents have good working relations with medical staff in their directorate teams. MM07 talks of the "*doctor/nurse thing about who's got the knowledge and the power"* surmising that "*if you know what you're doing and you can give a rationale of what you want to do clinically, then people will listen to you."* Similarly, MM14 describes the need "*to have a very good working relationship because of the diseases we treat"* and that "*we've got a very good group of medics who are very nurse focused, and we work very well together as a team, we work very closely."* It is noteworthy that MM14 describes a nurse-led service with "*nurses very much at the forefront of the care delivery*" with the co-operation of the medical staff, unlike the old model of medical care where "*the medical teams are still very much the medics, the nurses are very much the nurses*" *(MM14)*. There is an argument that professionalisation in nursing is a masculinised project, valuing technical proficiency

over care work where nurse practitioners (as in the case of MM14) act more as junior medics than nurses, thus succumbing to and reifying the existing medical hegemony (McMurray, 2010; Meulenbergs et al., 2004); this is highlighted by MM06,

> *Working as a nurse practitioner is very much more a medical model, you know, I was working more or less like a junior doctor and I wanted to get back onto the nursing side, and for me this was an ideal opportunity. (MM06)*

The gendered implications of the role relationships between the Matrons as nurses and medical colleagues do not surface directly in the respondents' talk however it is worthy of discussion given the masculinised medical hierarchy within which feminised nursing is subordinated (Crawford et al., 2008; Liaschenko & Peter, 2004, Taylor & Hawley, 2010). MM06 (cited above) wishes to return to her nursing roots rather than pursue a more technical, medical role as nurse practitioner, thus firmly identifies the Matron role within the nursing domain. This echoes the point made earlier (Section 6.3.1, p.130) that the Matrons each talk of the importance of the values of nursing care to their own practice; what this data suggests is a rejection of the medical model in preference for nursing based on the ideological principles of person-centred care (Keogh, 1997; Taylor & Hawley, 2010; White, 2002).

On the relatively few occasions where medical staff are spoken of, it is in the context of their general lack of involvement with the implementation of policy initiatives which are regarded as belonging to nursing, such as Essence of Care benchmarking; "*it was seen as a nursing initiative, it was very difficult to attract medical staff into this" (MM03).* It is accepted that medical colleagues will not involve themselves in nursing endeavours and the Matrons do not appear to want to challenge this; nor do they give any suggestion that they feel marginalized or subordinated as nurses within the patriarchal medically dominant system (Kelly, 1991; Fawcett, 2003). Rather, they present themselves as professionally autonomous, celebrating their skills as knowledgeable "*do-ers rather than discussers" (MM02),* who *"do everything, regardless if it's big or small" (MM14)*. Working at the "*grass roots*", "*making sure that the patients are well cared for" (MM12)* and "*making a difference" (MM10)* to patients is what nurses are *"really good at"(MM07)*. The Matrons embrace work which has congruence with nursing ideals and,

in taking ownership of caring work, are able to take control of their work, subordinate as it may be (Dent et al., 2004; Salvage, 1998). However, whilst the Matrons manage their inter-relations with medical colleagues, the fact remains that they do not have professional or managerial authority over them, which highlights inconsistency between policy and work practices (Currie et al., 2009); to enable the Matrons to fulfil their corporate remit, for example to fully implement Essence of Care, they need medical staff to cooperate but as MM08 points out,

> *Essence of Care is described as multi-disciplinary benchmarking, it should be but I just feel it would have got nowhere if it had been given to the medical staff to deal with. .. I know how they feel generally about clinical governance, you've got to drag them kicking and screaming to do it… medical audit, that's all they see as important, mortality and morbidity outcomes, and Essence of Care is not about that it's about the basics.*

This example highlights a problem in inter-professional working, managing elites. Professionals look to their profession and to their peers to determine codes of behaviour and acceptable performance standards at the exclusion of others (Freidson, 2001), and in doing so, will often "disdain the values and evaluations of those outside their discipline" (Quinn et al., 1996, p.11) with the result that "most professionals are reluctant to subordinate themselves to others, or to support organisational goals not completely congruent with their special viewpoint" (ibid. p.11). This is illustrated by MM14 who, with regard to encouraging medics to become involved in Essence of Care benchmarking, said "*some of them thought it was daft, not another bloody nursing thing, is what they would say, because they think nurses (laughs) have an awful lot of paperwork to do."* It is intransigence within the professional medical hegemony that undermines the Matrons 'corporate' authority in policy implementation. The problem of a lack of requisite authority over different occupational groups is not confined to the professional medical-nursing relationship; it extends to other groups such as externally contracted staff.

7.2.2 Working with Contractors

The Matrons have very limited control of crucial services for which they are directly accountable; this is particularly true of their lack of authority over contractors. This is illustrated when the respondents talk about working with other departments in the organisation on priority areas of cleanliness and hygiene; organisationally, the Matrons are responsible for managing the environment, to ensure high standards of infection control and cleanliness however they *"don't manage the domestic staff, they're managed by Hotel Services and we don't manage the Estates staff" (MM01)* hence their ability to take control of these essential services is significantly diminished as MM03 explains,

> *The only real objective that we've had problems with is the actual controlling of domestic services and the organisational structure and how we interface with these. These are old ways of working within this Trust and they're the barriers that you wouldn't actually step over.*

These problems reflect the impact that NPM-led marketisation and efficiency drives have had at the local point of delivery, as outsourcing of non-clinical services, for example, contract cleaning in hospitals, has become commonplace (Flynn, 2007). By not having control over the cleaning services within the organisation, the Matrons cannot discharge their professional duty to manage and maintain standards of cleanliness. This is indicative of the conflict between managerialist policy and professional delivery (Sehested, 2002; Currie et al., 2010; Taylor & Hawley, 2010; Washer & Joffe, 2006) and challenges the premise of professional autonomy as the Matrons clearly do not have complete autonomy over how to discharge their duties in line with their work remit to manage infection control; theirs is a different kind of autonomy, a heteronomy, where their work and organisation is subject to an external authority and mediated by other occupational groups (Dent, 2003). Unable to command complete control and autonomy over these aspects of their work, the Matrons have to find alternative ways of working with others to be effective in their own duties and responsibilities,

I can also make a difference by influencing, and I think that's really important. So it's the level of influence that is very pivotal to how effective that we can be as Matrons. (MM10)

There is recognition that the Modern Matron is "*a different role to the old-fashioned Matron*" *(MM12)* which immediately challenges the underlying logic for "bringing back Matron" to take authoritative control. The difference lies in the nature of power and authority that they exert, more focused on leading, empowering and influencing than commanding (Currie et al., 2010; Taylor & Hawley, 2010). This approach to managing is more of a challenge as MM01 explains,

I think it's a very difficult role in terms of the idea that you supposedly empower others to do their job more effectively, I think that's probably one of the things that's more difficult to do.

7.3 Visibility: interacting with patients

The archetypal image of Matron as authoritative and in charge is a positive aspect of their inter-relations with patients; bearing the title Matron has credence as a distinguishing factor of authority and importance.

The respondents are happy to draw from the legacy of traditional Matron, as stereotypically authoritarian and controlling (Bufton, 2005; Hallam, 2002) accepting this as the reference point that most patients, and especially older patients, have in understanding the role. The popular media image of Hattie Jacques' Matron in the popular British "Carry On" films, *"Ooh Matron" (*MM07, MM13; Figure 6.1, p.113), is a comedic parody, but the respondents take a positive view that the Matron role is "*what patients wanted and I think the patients quite appreciate it" (MM07)* and,

Certainly the older patients, some of them have experienced Matrons before, feel so much more reassured just by the title on a badge. If they're having problems the staff will say "I'll go and get Matron" and they're quite happy to feel that somebody'll actually listen to them. So it is quite nice. (MM13)

In light of the political context which led to the introduction of the Modern Matron post and the policy directive to be a visible presence (Section 3.4.1, p.63), there is pressure on the respondents to ensure that patients accept and are happy with the Matron role and this is evident in the data,

> *The big change in becoming a Modern Matron was going back in to uniform and being visible to patients, which was a positive thing. We've had so much publicity, I think the general public have a feel for why we're in post, and we do have influence. (MM11)*

Having a *"visible presence"* for "*staff on the shop-floor" (MM03)* is recognised as an important aspect of building positive relations with staff with respondents telling how they *"walk around the wards and chat to the patients", "have a bit of a rummage around" (MM02)* and "*get out onto the wards to nosey around and see what's happening" (MM08)*. The implication here is of the Matrons asserting their professional authority, visibly 'checking up' for both patients and staff to see.

Meanwhile, MM03 who had been Assistant Directorate Manager and found that *"the significant thing that's changed it's put me into a uniform… I was basically a suit that went around and did all of these things, and the uniform gives me an added advantage."* This "added advantage" is that the uniform asserts clinical credibility as MM02 illustrates,

> *I was actually bed-bathing a patient on one of the wards when one of the consultants was doing his ward round and he happened to see the uniform through the curtains and knew who it was, I heard him say "Oh is that Matron in there doing a bed-bath?" and I was "Yes" and "Ooh, doing proper work" (laughter). (MM02)*

There is a sense that the uniform facilitates the Matrons to integrate with rather than differentiate from their colleagues and this actively helps them to work alongside other staff. However, it can also detract from the Matrons' level of seniority as several respondents highlight how because their uniform is not the traditional navy, their

authority can be overlooked, "*people come in and they bypass the lilac and they go for the navy blues, I suppose it's what they're used to, you know" (MM13)*.

Figure 7.1: A Matron in Lilac

(Source: Trust Website)

At the time of this research, navy blue uniforms were worn by ward sisters, the implication being that Matron's authority was therefore undermined by subordinate nursing staff. One respondent tells of a medical colleague not realising she was a Matron because *"people don't automatically associate this colour* [lilac]*"* as "*being an authority figure" (MM07).*

Interestingly, MM03, the male Matron, wore a white tunic more in line with medical apparel than nursing staff. MM03 recognises he is "quite unusual" in post as a male Matron[9] and talks about being respected and liked because of it; he uses the visibility of the role to his advantage when building relationships with staff and patients alike. The issue of nursing as a feminized profession arises through MM03; he is the only respondent to make a specific reference to being a male Matron, referring to it as atypical or "token man" (Pullen and Simpson, 2009, p.562) but he does not suggest that this is problematic. MM03 speaks in line with a more managerialist discourse and aligns to a more corporate perspective about his role than his female peers. He talks objectively and authoritatively as being an experienced manager and takes a patriarchal stance amongst the Matrons, referring to himself as "*the elder statesman of the group*"; someone to whom patients and staff turn for advice thus discursively constructing masculinity in a traditionally feminized role (Pullen and Simpson, 2009).

Whilst visibility and authority on the wards is perceived to be positively received by patients, one respondent, newly appointed to post and a newcomer to the Trust, presents a slightly different perspective, the need to be visible in terms of doing what her manager wants,

[9] there is one other male Matron in the Trust who opted not to participate in the research

> *So she wants us to be visible and on the ward and cleanliness is high on her list, it's high on my list. So I do cleanliness audits in my own areas regularly and I go and say hello to patients, look at the staffing and the establishments on the wards, you know, those sorts of things. (MM15)*

This implies subordination to managerial hegemony as MM15 performs front of stage (Goffman, 1990) to fulfil policy rhetoric and senior management expectations. Policy rhetoric and public perception both play a part in constructing the Matron role, as incumbents to the role seek positive affirmation that their presence and actions meet the expectations held by both the public and policy-makers. It is necessary to again note the subjectivities involved in respondents' comments; there is no corresponding data to verify the assertions that the Matron role is received positively by patients in this Trust although Bufton (2005), in a study of patient perceptions of the Matron role found that the Matrons were not as visible and accessible to patients as rhetoric would suggest.

7.4 Concluding Thoughts

The data suggests that individual Matrons are able to exert professional authority within their directorates in relations with nursing staff, "*identifying the right people to make it important… I mean I think it's my job to, for want of a better word, manipulate the people who you know will make things happen isn't it?*" *(MM11)* but they do not have requisite power or influence over other health care professionals or occupational groups. The Matrons try to perform across hierarchical and professional boundaries but find it difficult to move beyond the confines of organisational structure and hierarchy constrained by both medical and managerial hegemony (Currie et al., 2010; McMurray, 2010; Meulenbergs, 2004). This exemplifies the role transition conflict (Currie et al., 2010) that new public management practices exert on individuals; despite their professional autonomy and influence within their own domain of nursing at directorate level, the respondents struggle to work beyond this familiar territory.

What this discussion has shown is that the Matrons have to mediate inconsistencies and contradictions between policy rhetoric and occupational hierarchies. Power and

authority, defining aspects of professional identity (Evetts, 2005; Freidson, 2001), are shown to be relational, contingent and dynamic forces shaping Matron identity: as clinical leads to subordinates within their individual directorates, they can exert authority conferred through professional credibility; as subordinates to medical colleagues, they create space for professional autonomy through a discourse of care; with contractors, they manage through influence. This is the nature of the hybridized role, continually negotiating and reconfiguring role and identity in relation to 'other' (Brewer, 2001; Meulenbergs et al., 2004; Paulson, 2006).

In the discussion of findings so far, the data has shown Matron acting as an individual, differently and separately from other Matrons. In terms of identity formation, I have suggested that it is relational, based on deeply-rooted values on principles of care, to which individuals are personally committed and deriving from their role relationships as they are positioned 'above', 'beside', 'below' and 'beyond' through competing discourses and interactions with others across occupational and organisational boundaries (Alvesson et al., 2008); however, as Brewer (2001) states, there are "many faces" (ibid. p.115) to social identity; the next chapter discusses an alternative and contradictory "face" of Matron identity, constituted through cohesive group action around policy implementation.

8 MODERN MATRON: A COHESIVE ROLE

In the previous two chapters (Chapters 6 & 7) I have argued that the data shows relational identity construction among the Modern Matrons occurring at the level of the individual, through and contingent upon role relationships across occupational and organisational boundaries. The person-based relational identification occurs through alignment with a vocational ideology of nursing care, and manifests in a prioritisation of clinical practice over managerial work. Authority, integral to professional identity, is conditional on the inter-relations between individual and 'other' unlike the unitary authority of the archetypal Matron of old, indicative of changes between traditional and contemporary nursing management styles (Currie et al., 2009). However, this individual analysis (Exworthy & Halford, 1999) only tells part of the story; identity construction is situational and emergent resulting in the possibility of multiple social identities (Ainsworth & Hardy, 2004; Ashforth & Mael, 1989; Pullen & Simpson, 2009; Svenningson & Alvesson, 2003); the data reveals an alternative and contradictory perspective on the constitution of Modern Matron, that of collective identification.

This chapter discusses identity construction through collective action, illustrating through the data how the Modern Matrons work cohesively creating a collective identity with shared purpose; maintained through salience (Ashforth & Mael, 1989) of collective action with deep-rooted values; this identity is a "discursive accomplishment" of the prevailing social context (Alvesson & Karreman, 2000; Brewer, 2001) and of policy rhetoric.

8.1 Congruence through Corporate Collectivity

As discussed previously (Section 3.4.1, p.63), the Modern Matron role has been presented as a political construct to address public and professional concerns about poor standards of cleanliness and basic nursing care as reflected in policy documentation (DH, 2003; Smith 2008a & 2008b). This is a new role introduced into the nursing hierarchy and as such needs to be positioned within the existing organisational structure; the process of establishing the role inevitably leads to a reconfiguring of professional

identity as the Modern Matron 'becomes' the hybridized professional-manager with a remit to implement policy and improve quality of care provision.

In the data, the Matron role is perceived to be central to implementing corporate policy, "*as a group of Matrons it's expected that you will do your fair share of Trust or corporate things" (MM03)* in support of the Trust's strategic objectives and that *"Matrons are extremely important in ensuring that happens, one of our key roles is ensuring that Trust policy, procedure and guidelines is adhered to" (MM10).* The respondents talk of their "*central corporate role*" *(MM02, MM10, MM14)* and their collective responsibility to *"all work together as well strategically for the Trust" (MM08)* with an emphasis on collective action, "*together as Matrons we look at things and see where we can make improvements and things. I just feel we're a positive group and I think that's to the benefit of the Trust" (MM12).*

Cerulo (1997) argues that there is conscious co-ordination of action within collective groups whereby members develop strategies to establish and maintain a collective identity. The respondents' talk promotes the Matrons as a cohesive group with requisite skills and authority to perform and lead at the corporate[10] level within the organisation; this assertion of their centrality to strategic corporate activities both reinforces and protects their collective identity as professionals acting to a managerialist discourse of reform (Ashforth and Mael, 1989; Goffman, 1990; Mackey, 2007). The Modern Matrons present themselves as a group with shared responsibilities to the corporate agenda; congruent at corporate level in the organisation and different to the individualized role performances that occur at directorate level. Professional groups are identifiable by a unified, self regulated approach to collective action, informed by shared purpose and values and articulated through autonomous decision making (Ashforth and Mael, 1989). The data reveals that, at a corporate level, the Modern Matrons do perceive themselves to be a unified group; acting with shared purpose and autonomy, in line with policy prescription.

[10] I use the term "corporate" to describe senior level management of organisation-wide policies

8.1.1 The Professional Group: the Modern Matron Forum

This collective action is demonstrated through a monthly meeting, the Modern Matron Forum. Whilst there are other regular staff group meetings (for example, senior nurse meetings), this forum has been convened specifically for the Modern Matrons as a means by which they can meet and share ideas and concerns about pertinent issues, in relation to the Matron role, across the Trust. This exclusivity of membership, or "social closure" (Freidman, 2001) is a trait of professional in-group behaviours.

Observations[11] of the forum show that the meeting structure offers a regular point of contact for each Matron to be visible to one another and to the senior director (D1). The forum enables the Matrons to "*exchange information and network*" with each other (MM07); communicate policy; discuss new developments; share ideas and agree collective action on key issues. This function to bring the Modern Matrons together is essential to their collective identity as it brings together an otherwise disparate group of individuals, working independently across the Trust. That said, not all Matrons can attend every forum, a reflection perhaps of how busy they are within their individual directorates, as MM02 expressed, "*there's only two things would put me off, holidays or a crisis, otherwise I go. If somebody's arrested on the ward and they can't cope, then Matrons' forum is on the back burner, but otherwise that's the priority.*" The forum meetings observed gave the impression of a friendly supportive environment for Matrons to come together if they could, some would be present throughout, others arrived late or left early depending on work and staffing commitments, but it is the mutual support offered within the group that is reflected by the respondents themselves, "*there's a sort of common bond and you work together…the strength is in the support…I think everybody's got a mutual respect*." (MM07).

The Modern Matron Forum enables the Matrons to work together on central issues relating to policy. It is at these meetings that the Matrons collectively decide on how to implement policy dicta and they have autonomy in the sense of setting and coordinating priorities and action plans within the Trust, cascaded through the individual directorates. With regard to policy implementation, the senior director emphasizes that it is the Matrons who have "*got a responsibility to make this happen"* and have to decide *"how*

[11] Personal Notes, June 2005

are we going to do it" (D1) thereby confirming them collectively as professionally responsible with autonomy on deciding how to deliver the corporate directives within the Trust.

This implied autonomy is further reflected as the respondents talk about themselves deciding as "*a group of Matrons how it was going to be" (MM03)* and prioritising action, "*at the Matrons' meetings we decided that we wanted to make issues like cleanliness and the environment a priority" (MM08)*. There is a real sense that the Modern Matron Forum reflects a strong, identifiable corporate role embodied by the Matrons who speak collectively of themselves and their responsibilities, "*as we've got a really good understanding of our Governmental targets and our local targets, so we tend to know which direction we're going" (MM03)* and that they "*have an extremely pivotal role in rolling out" (MM10)* key policy and strategic tasks Trust-wide.

The forum also offers a medium through which to legitimise their role to others; one respondent describes the reporting line from the forum to the Trust Board, wryly commenting that,

> *I think we were really just looking at what we wanted from the role, looking at what we felt we'd achieved, we drafted that all up to [D1] who fed it back to the Trust Board. I suppose because we are quite expensive, they wanted to know that we getting value for money (laughs) probably, which is fair enough (laughs). (MM13)*

This suggests that the group is politically astute and cognizant of the need *to be seen* to be performing in line with the managerialist discourse of performance efficiency and value for money, acting within a 'culture of performativity' (Dent & Whitehead, 2002: this will be discussed further in Chapter 9, Section 9.2.2). An example of this is the decision to conduct a uniform audit as part of their work to improve infection control policies within the Trust and seek "*compliance to uniform policy" (MM09)*, which involved "*patrolling the exits and entrances to all of the sites catching nurses travelling in their uniforms" (MM06)*. This is serves as a reflection on the political context in which the Modern Matrons operate and the impact this has on their day to day working. The collective identity assumed by the Modern Matrons is discursively constructed

(Alvesson & Karreman, 2000), a social artefact (Cerulo, 1997) elicited through social context (Brewer, 2001); the existence of the role and subsequent actions within it are constructs within an over-arching discourse of health care reform. In the context of public attention on MRSA (Section 3.4.1, p.63), being under such public scrutiny the Matrons seize the opportunity to collectively act on infection control in an authoritative way, as reflected in this detailed excerpt,

> *In the last year I know we've had issues relating to staff travelling to work in uniforms, it sounds a bit fuddy-duddy-ish but we've had issues within the hospital. I mean firstly there's an issue of the professional image of the organisation. We're getting slated left, right and centre regarding infection rates and stuff like that, and the two just don't marry. People hopping on a bus to go home in their uniform (a) it's not professional and (b) it's not doing its best to help infection spread and stuff like that. I think it's how do we look at the mindset behind this, why are people doing this sort of thing. When we were talking about uniforms one of the things we decided to do was a dawn patrol, man the doors waiting for staff coming in and catching them. It wasn't as a punitive thing, it was just that we've got a policy that says you should get changed, can you tell us why you've come in your uniform? Some of the excuses were fabulous. But these were things that we would be looking at, we need to understand why people are actually doing this. (MM03)*

This example shows the Matrons unified action in direct relation to macro level policy in a visible and tangible way, by physically standing at the door, spot checking nursing staff as they begin or leave their shift on Trust premises. The language used by the Matrons ('compliance', 'patrolling', 'catching') suggests an exertion of power and authority over subordinates that fits with the traditional image of Matron as reflecting order, authority and morality (Washer and Joffe, 2006). Working collectively, the Matrons exert their professional authority over their occupational subordinates (Evetts, 2003b; Mackey, 2007); utilizing and reaffirming the Modern Matron's claim to

legitimate authority and the power to act, "*to give it the sort of gravitas" (MM08)* and "*the right kind of power to get things done, power to make changes" (MM11)*.

The Matrons have authority conferred upon them through the institutional rhetoric of traditional Matron where *"the old style Matron comes in and tells them what to do" (MM13)* and the positioning of the role within the organisational hierarchy, with support from "*power players" (MM07)* on the Trust Board for whom the Matron role is a means by which to address the political drivers of "*care of the patient for basic necessities…that's all they want" (MM02)*. This then is a unitary exercise of power in which some aspects of the traditional identity of Matron are claimed and utilized as both practical (enhancing cleanliness) and political (demonstrating effectiveness against assigned responsibilities) acts. In working towards policy goals and on subordinate others, they work collectively to assert an identity in which the Matron has both the license and mandate to intervene professionally.

The Matron role is a political and social construction defined by historical legacy, institutional policy and through social interaction in the organisational setting (Alvesson et al., 2008; Berger & Luckmann, 1991) which while at times treated with disdain, is also claimed by the same practitioners when professionally expedient.

8.1.2 A Corporate Identity

In the discussion so far, the data suggests that the Matrons subscribe to the traditional image of Matron as reflected by public perception and policy rhetoric; they uphold their professional status as senior figures of authority by embracing the managerialist discourse of performance management and efficiency, defining themselves by their actions of standard-bearer for institutional policy, a visible, unified group working together for the organisation; performing a corporate role.

A collective identity emerges that I have termed "Corporate Matron"; this is the "front of stage" performance (Goffman, 1990) representing an idealized image of Matron as authoritative and autonomous, taking action against institutional problems and meeting the expectations of their audience, in this case the people to whom the Matrons are accountable, the general public, Trust Board and Government. This corporate

performance is reliant on collective teamwork, demonstrated by the Matrons' co-operation with each other on mutually agreed actions. Identity theory suggests that the more a social role aligns with an individual's personally held values and beliefs, the more salience there will be between role and individual hence identification will be stronger (Ashforth & Mael, 1989); the same logic can be applied to collective identity whereby congruence between members' beliefs, values and purpose is essential to the maintenance and protection of their collective identity (Stets & Burke, 2000). For the Modern Matrons, this salience emerges through a discourse of "care", striking at the heart of what it means to be a nurse, and their own sense of self,

> *What I wanted was a strong pull towards looking at basic care, that's what the Matron's role is. (MM02)*

During the interviews, when asked what they most liked about their job most respondents inferred that being able to 'make a difference' to the care that patients receive is very rewarding (D1, MM05, MM08, MM10). Whilst it could be argued that this is corporate rhetoric, a Department of Health policy slogan (1999a), in-depth consideration of the data shows that caring for patients is a recurrent and consistent theme.

8.1.3 Shared Ideological Values

There is a strength of feeling towards being responsible for providing high standards of patient care, "*the patient is at the end of whatever you do, regardless if you're a Matron, the health care assistant or the domestic, the end is the patient, and delivering the best care for that" (MM14)* and that this is central to the Matron role, "*I could maintain a lot of clinical input, see what the pressures were and thought that it was a job where I could do something to alleviate some of those pressures" (MM01).* Patient care through basic nursing skills is repeatedly highlighted as the motivation for the Matron role, "*that's what we're all here for isn't it, better patient care" (MM12)* and *"what I like about being a Matron is that you're in touch with patients at a hands-on level, so you're making a difference" (MM10).* At this level, respondents speak personally about ideological values they attribute to the role of Matron, and nursing more broadly.

There is a strong sense in the data that respondents universally define themselves as nurses and this is a very positive association for them, *"it's just nice being a nurse" (MM04)* and *"I enjoy everything" (MM12)* about nursing. Similarly, MM01, when recalling her career path to Matron, consciously made a choice to return to a ward sister post from a research role because she *"just missed being a nurse" (MM01)*. Being Matron still enables them to be "*very much in contact with your nursing roots" (MM10)* and this is valued, as illustrated by MM06 who applied for the Matron role from a nurse practitioner position because *"it was back being more nursified."*

As individuals and collectively, the respondents infer a value oriented identity based on a philosophy of altruism (Fagermoen, 1997; Taylor, 1997), where fundamentals of care-giving, the "dirty work" (Hallam, 2000) of bedside nursing, is central to thought and action, "*because that's just what nursing is" (MM08)* and "*it's looking after somebody that you don't need to have years of experience to do. It's general nursing care" (MM16)*. An ideology of vocational care-giving is fundamental to their self and collective identities, as powerfully demonstrated through their talk of a loss of care within nursing.

8.1.3.1 A Perceived Loss of Care

In the year preceding the data collection for this research, a resolution was put forward for debate at the RCN Congress that "the caring component of nursing should be devolved to health care assistants to enable nurses to concentrate on treatment and technical nursing' (Scott, 2004, p.581). This resulted in a media storm that nurses were "too clever to care" and "too posh to wash" (BBC News, 2004; Hall, 2004; Moss, 2004). The debate centres on a concern that professional nursing encourages and rewards technological and medical skills whilst eroding and devaluing the vocational caring skills in the registered nursing role; a debate which still has currency some five years on (Fleming, 2009). In addition, Currie et al. (2009) comment that the move to professionalise nursing has led to significant gaps in basic nursing practice which has in turn led to a decline in standards. The respondents appear to concur with this view.

They talk about their concerns in relation to the prevailing discourse of delivering better quality care with particular relevance to Essence of Care benchmarking as this focuses entirely on managing performance around fundamental aspects of basic nursing care (DH, 2001a). They are keen to reassert their professionalism as MM14 says, "*we're not all mean and we don't all not deliver care, because nursing at the minute has not got very good press."*

Half of the respondents speak emotively of their concerns about the demise of basic care in contemporary nursing, feeling "dismayed" (MM02), "frustrated" (MM16) and "saddened" (MM06; MM07; MM11; MM13) by a collective perception that newly qualified nurses are neither equipped nor inclined to perform the basic aspects of nursing care, as illustrated here, "*I feel sometimes here that the student nurses are wanting to run before they can walk, they're wanting to do the IVs and cannulate and venepuncture but don't know how to do a proper bed bath, and I find that frustrating" (MM16)* and "*they have all the academic knowledge, but I don't know if they understand all the best practice and why we do certain things and how to make your patient comfortable, how to talk to them. I think it's sad for them" (MM13)*.

For the Matrons who do not express an overtly emotional reaction towards this issue, there is recognition of the function that education and training has in ensuring quality nursing care, "*it's fine to be wonderful at clinical work, but you do need the education as well*" *(MM14)* and that "*we always wanted it to be a profession and be professionally recognised"* however, this is tempered by a view that *"maybe it's gone too far" (MM04)*. The respondents reflect on how nurse training has changed from *"the days of Florence Nightingale" (MM06)* and is more classroom based with less practical learning from the ward, where *"it has become too academic and the students aren't exposed to basic nursing care to have that embedded in their practice" (MM13).* The suggestion here is that "*standards perhaps have slipped" (MM06)* in the way student nurses are trained and, as a result, nursing *"has struggled with that"* (*MM03*).

It is through this talk, emphasising strength of feeling about the '*loss of care*' (MM07; MM11; MM16) and basic nursing skills being "*forgotten*" (MM06) and "*slipping away*" (MM02) that deep-seated values about being a nurse, how to care with respect and

dignity for the patient and governed by a moral and ethical code, the *"whole ethos of how we work" (MM07)*, become visible.

8.1.3.2 An emotional response

The emotional responses to the state of nursing practice intimate emotional labour within nursing (Gray, 2009a; Gray, 2009b, Allan & Smith, 2005); this perceived 'loss' of basic principles of patient centred care jeopardises the core values of their chosen profession, risking their ability to deliver and sustain quality in nurse-patient interaction, through the one-to-one relationship with patients, a fundamental aspect of patient-focused care. This has quite a profound effect on one Matron in particular; MM07 spends a significant proportion of the interview talking about the state of nurse training today in comparison to her own experience where issues of tidiness, cleanliness and respect for others are very much integral aspects of self,

> *I don't know whether that's a generational thing as to how people have been brought up and what they've been taught from home but there's a lot of common sense issues, that you tidy up after yourself, that you maintain a clean environment, I think you've got to teach people that now, whereas that was integrated into my upbringing really. (MM07)*

It is clearly something that she feels upset and frustrated by and this is reflected in her narrative,

> *They don't go through the theory and then relate it to practice, people just pick up very bad habits, they're not washing out bowls or washing receivers that they use, and not using soap and water to wash cups with.*
>
> *You've also got nurses who've got absolutely no idea of anatomy and physiology and do not understand how the body works, because there aren't any sciences the course up here. They're teaching nurses to do venepuncture and cannulation in their training, but I bet they haven't got a clue about the structure of blood vessels. People have said 'oh what on earth does an adrenal gland do', they don't understand what drugs do, they don't understand how the body works.*

These experiences lead MM07 to talk about the state of nursing today as *"scary", "mad"* and *"frightening."* Whilst atypical in the fervour and degree to which these issues are vocalised, MM07 does reflect concerns that other Matrons share with regard to the state of modern nurse training.

There is a depth of feeling about the need to re-establish the basic principles of care in nursing; in relation to this, the Matrons' support for the Essence of Care benchmarking initiative is very evident, despite the challenges encountered in implementing Essence of Care within the individual directorates, particularly in relation to leading and managing change with requisite authority across different professional groups. This managerialist device (Hewison, 1999) falls directly within the remit of Modern Matron to lead on improving standards of care; it also resonates with their personal motivations to redress perceived problems in delivering patient focused care and thus offers salience between individual values and collectivity which in turn, strengthens their collective identity (Ashforth & Mael, 1989).

8.1.4 Reinstating Fundamental Values of Care

The Essence of Care policy initiative, by its title alone, has resonance with the fundamental ideology of nursing as a caring profession, "*I was just talking to somebody else and said that really Essence of Care is very much the fundamentals of nursing care"(MM07)* and *"the principles behind it were really, really well founded" (MM03)* and this discourse of care appeals directly to the professional values held by the respondents (Hewison, 1999), "*it has helped put nurses back in touch with the fundamentals of care"(MM10).*

When speaking of how basic principles of nursing care have been lost, the respondents subscribe to policy discourse that Matron is ideally situated to reinstate the fundamental values of care back into nursing, drawing from the traditional Matron identity by reflecting back to how "*it was all so much better when the Matron was here" (MM08).*

Essence of Care benchmarking presents as a timely intervention which the Matrons have used to their advantage, helping to establish their role as clinical leaders by using policy as a vehicle for conveying the fundamental principles of care to subordinate nurses and

other professionals (e.g. midwives, medics), *"it has made nurses think about what they do" (MM14)* and "*it has made people focus on their work, to think about that" (MM07)*; the emphasis on reflection and learning inherent to the benchmarking process positively reinforces these values in practice, "*it does get people to look at their practice and it gets people to critically evaluate their own practice" (MM01)* and that is something from which "*you can only benefit really" (MM16)*. Essence of Care provides the Matrons with an opportunity to perform as "Corporate Matron" front of stage (Goffman, 1990).

8.2 Performing Corporate Matron: implementation of Essence of Care

It is clear that Essence of Care has been regarded as a key priority for Trust, that "*nationally it's a necessity and I think the Trust has run with it" (MM05)* particularly with regard to the direct link that Essence of Care has to the performance management of the Trust[12], *"we've got this organisational view now…because in the Health Care Commission standard now Essence of Care features in there"* (*D1).*

The perception amongst the Matrons in this Trust is that Essence of Care, *"is the biggie (MM12);* "*a big national thing and a must do imperative" (MM05); "a must do" (MM06, D1)*; something that "*is important, you've gotta make it happen" (D1*) or as one respondent puts it, something that Matrons *"were given, volunteered, coerced" (MM01)* into taking responsibility for, "*there we were with this Essence of Care that we had to implement, this Government initiative and it was just given to the Matrons" (MM12)*. This illustrates the circumscribed nature of the Matron role and responsibilities, working to externally driven policy and corporate directives; their autonomy extends to decisions on how to implement the top-down government dicta, not what the policy should be.

It is important to note that the research interviews took place as an initial phase of implementation was drawing to a close; when asked to "tell me about Essence of Care" the respondents report on the process of implementation rather than outcomes, for example, changes to practice as an evaluation of outcomes from the initial phase of benchmarking had not been undertaken at this stage.

---

[12] Essence of Care benchmarking is an integral part of Clinical Governance which in turn, is integral to the performance management system against which all NHS Trusts are audited.

8.2.1 Implementing Essence of Care across the Trust

The respondents recollect their initial responses to the policy documentation when it first launched; that this was "*a big thing" (MM10)*, a *"huge document" (MM03)* which was *"complicated" (MM02), "repetitive"* and *"not user friendly" (MM05)*. Initial perceptions of the Essence of Care toolkit were of *"a file that sat on the shelf gathering dust" (MM01; MM13)* and a significant challenge to implement, particularly for busy clinical staff wary of "*another paper exercise" (MM09)*, perhaps reflecting a pervading notion of reform fatigue (Walshe, 2010) at the time. It also suggests a rejection of the overtly managerial nature of the task in comparison to the important work of clinical practice, indicative of professional-managerial tension in the Matron role (Dopson, 2009; Paulson, 2006). The apprehension felt towards the task of implementing Essence of Care is encapsulated by the words of D1,

> *The file arrived in the Trust, which is still on the shelf, a hundred and thirty odd pages, A4 file, with very little guidance, and it was kind of, there's the file, this is important, you've got to make it happen, and it was very difficult to relate .. that pile of paper to what was happening in practice and to think about how you applied that in an organisation this size. .. we sat down and thought how, where do we start, and I think it just seemed an enormous undertaking. (D1)*

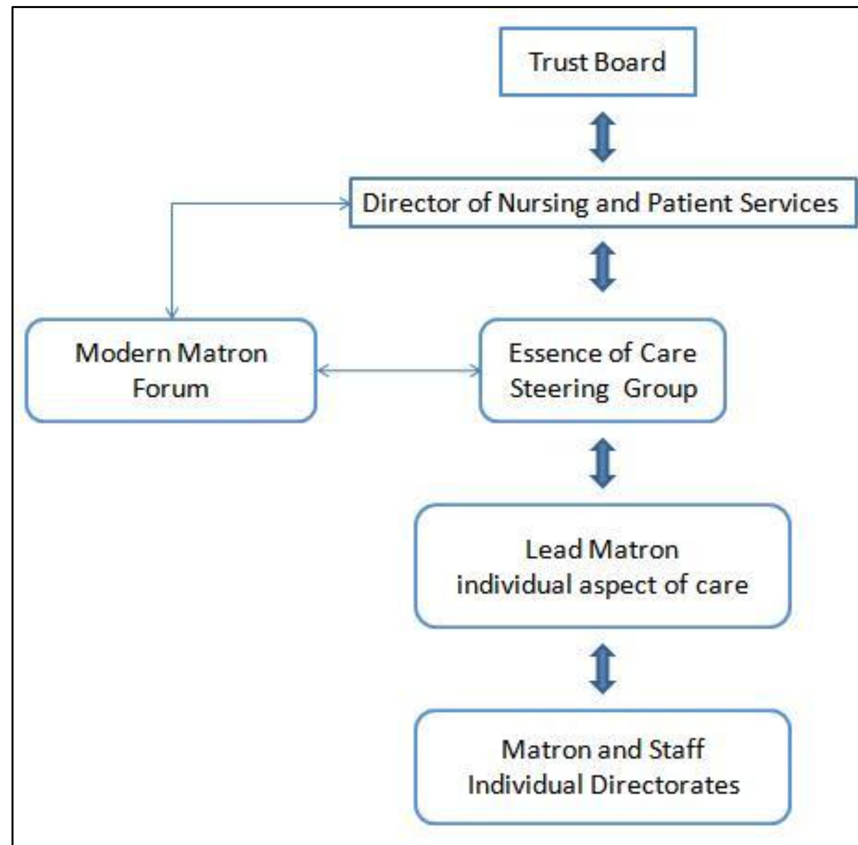
Within the Trust, initial attempts at implementation of Essence of Care were *"disjointed" (MM04)* and *"a bit ad hoc to start off with" (MM08)*. The size and scope of the organisation presents a significant challenge, particularly when trying to *"to get every clinical area benchmarking against a specific sort of benchmark at exactly the same time in exactly the same way with exactly the same format to their reporting mechanism" (MM01)*. The Matrons assume collective responsibility for the task, working together to develop and put into operation a *"whole coordinated approach" (MM05)* agreeing that *"we as Matrons were going to do it and we were going to do it in an organised way, and everybody do it all at the same time across the Trust" (MM08)*.

There is a clear indication of the Matrons' autonomy, within the given confines of their organisational remit to lead on implementation, as they take decisions on how to

implement the task, *"we had to try and understand how we could practically introduce it and that was the focus on the whole of our approach of Essence of Care. We didn't want it to be another dust collector, we didn't want it to be another door stop, we wanted it to work" (MM03)*.

Organisationally, the Matrons set up an Essence of Care steering group which acts "*as a subset of the Modern Matron Forum*" *(MM10)* and comprises Matrons who each have "*volunteered*" (MM01, MM02) to take responsibility for managing the communication, action planning and report writing for an individual aspect of care. They take the lead in guiding other Matrons and staff to roll out Essence of Care in their individual directorates. Once benchmarking activity has been conducted in the directorates, i.e. on wards and in outpatient clinics, action plans are identified and a directorate report written. This is sent back to the Lead Matron, who in turn, reports through the Essence of Care Steering Group to the Director of Nursing and Patient Services and ultimately to the Trust Board (Figure 8.1). An Essence of Care co-ordinator has also been put in place to *"chase up the reports and pull things together" (D1)* which has *"made a difference" (MM02)* and the process has "*been cascaded down well*" *(MM07)*.

Figure 8.1: Implementation Structure for Essence of Care



The Matrons speak very positively about their success in developing an "*extremely cohesive organised standardized" (MM10)* process for Essence of Care, transforming it from an unwieldy document *"into something which is real and usable" (MM03)*, whilst recognizing that *"it's been hard work…it was a huge, huge task…and I think that the way that we've approached it has allowed us to look at it systematically" (MM01)*.

What is evident from this depiction of the process of implementation is the desire for organisational structure and control. The Matrons have put into place a hierarchical structure through which they can impose authoritative control, thus taking a functional, managerialist approach to implementation, "cascading down" through this; this is reminiscent of a top-down approach to implementation (Mazmanian & Sabatier, 1989). However, whilst the Matrons take control of the process they have created and initiated in this way, the process of implementation itself is experimental (Matland, 1995) as the

Matrons have "corrupted" (Lozeau et al., 2002) and changed policy documentation to fit with their organisational structures and practices, through an iterative process of trial and error.

8.2.2 Validating Corporate Matron

The collective action on implementing Essence of Care illustrates how the Matrons have engaged with and rewritten the managerialist script of the benchmarking and audit process, moulding it to fit with their own frame of reference, to increase awareness of the ideology of improving patient centred care (Bolton, 2003; Hotho, 2008),

> *We tried very hard to say this is not a big stick to beat people with. This is an opportunity to learn. It's about improving practice not about highlighting bad practice. So we deliberately didn't share scores, didn't develop league tables, we let people do their comparing and sharing at local levels. (D1)*

When asked to describe any changes that had occurred as a result of the benchmarking initiative and what value it had brought to the organisation, the broad responses were that it had served to raise awareness of standards of basic care in practice and had helped to focus attention on priority areas, for example, hand-washing in relation to infection control; it had enabled better communication with staff, *"it's made you think about how you communicate with staff and what they actually understand" (MM07)*; provided evidence based information which the Matrons can use to facilitate change, for example, MM11 used information collected on Privacy and Dignity to support a redesign of the Gynaecology department, "*thinking around my needs of Essence of Care I was actually able to use that to influence the new ward"*; and it had also helped to improve patient communication and staff-patient liaison,

> *I think now patients are more aware of what's what and I think because of that it's just been more positive. I think we would probably involve patients before informally, but it's probably more formal now. (MM12)*

For MM05, Essence of Care "*was like a big giant problem that we've kind of addressed*" thus confirming the Matrons as problem-solvers, in line with policy rhetoric (Washer & Joffe, 2006). The respondents talk of the Trust-wide approach to Essence of Care as a corporate success story; that they have chosen *"by far the best way to implement it" (MM04)* and that "*in a million years, we would not have got where we are now if we hadn't taken this approach. I think really it is just amazing to have achieved that and to have got it into that kind of a format really" (MM01)*.

There is a sense that, by making a success of Essence of Care, the Matrons are legitimizing themselves in their role. D1 perhaps encapsulates this best,

> *More points for nurses, because we've got all this information…now we can produce a set of guidance notes that shows the process we've used, the audit tools we've used, the action plans that we've developed, and soon, hopefully, the audit that shows that we've actually made a difference. (D1)*

The comment, "*more points for nurses*" is a victory salute for the underdog as the subordinated nursing profession demonstrates managerial capability and positive impact, gaining recognition for these achievements.

For those Matrons who have been less involved with Essence of Care, there is a clear sense of failure and regret, *"Essence of Care's been hard. It's been hanging over you like the Sword of Damocles" (MM12)* whilst MM11 reasons, *"part of you thinks 'that's me as chair' and I didn't hold it together, but part of you has to live in the real world that people have other priorities and service demands, so you haven't got to take it so personally."* Meanwhile, MM15 says, *"I feel really guilty that I haven't given it priority and I will make sure that I get this group going again … I'm determined that I'll get that done, because I've been given this as an area of responsibility" (MM15)*. Individually,

the actions taken by the Matrons directly impact on their perceptions of self and role; being disparate from the collective risks their legitimisation as Matron, as MM13 says, "*there may have been implications for me, that I wasn't fulfilling the role if I hadn't done it."*

There is a degree of kudos attached to their achievements as reflected in their comments on how 'they' as an 'organisation' have progressed with Essence of Care in comparison to other Trusts. MM02 talks of having been at a 'Nursing Times' conference on Essence of Care in London to find *"it was absolutely amazing to see the amount of time and effort I think that this Trust has put in. There aren't many around the country that have it rolled out to such an extent" (MM02)* and "*we've taken the message out to a lot of areas of how we've turned Essence of Care around in our Trust, and I know a lot of other people have then come and asked us for more information and taken things back to their own areas" (MM11)*. This is echoed by the Director of Nursing and Patient Services who commented about gaining public recognition through *"a nice big half page spread in the [local newspaper] about the role of the Matron and fundamentals of care, and that did a lot to raise the profile as well" (D1).*

This public recognition serves to reify the corporate identity of Matron and supports their collective action in meeting their professional mandate to act on improving standards in relation to better quality patient care. There is a confidence in the respondents' talk about their collective efforts, something which is important to them; it is this very visible and high profile action to tackle a corporate priority that confirms the Matron role to lead with authority and promote high standards of care.

Public recognition of the Matrons' actions helps in the construction of their corporate image, illustrating the inter-relational social process of identity construction (Berger and Luckman, 1991). This also highlights the importance of being seen to be successful as Modern Matrons; performing to a broad critical audience (Goffman, 1990), including the media, the Health Care Commission, the Trust and the public, there is pressure to deliver to stakeholder expectations.

What the data suggests is that by implementing Essence of Care, the Matrons have been able to establish themselves in their role and meet their own objectives. This speaks to

the notion of "discursive accomplishment" (Alvesson & Karreman, 2000), whereby Essence of Care represents the prevailing policy discourse which the Matrons collectively act upon, and in doing so, constitute their corporate identity. The collective action around Essence of Care personifies the espoused theory of Modern Matron (Cerulo, 1997) as a figure with authority to take autonomous action, be a visible presence in the organisation and an advocate for basic standards of care.

I suggest that, as an audit of clinical practice, Essence of Care benchmarking is symbolic of the "culture of performativity" (Dent & Whitehead, 2002) prevalent at the macro level of organisational reform. Through their enthusiasm and support for the initiative, the Matrons engage with and sustain the managerialist approach to performance management as an effective way to govern standards of care delivery. By excelling in setting up and implementing the benchmarking initiative across the organisation, Corporate Matron aligns to the managerialist discourse and in doing so, reconfigures Matron's identity as legitimate and credible in the new managerial order.

8.3 Concluding Thoughts

The engagement with Essence of Care, as described by respondents embodies political rhetoric about what the Modern Matron role *should* be; a publicly recognised position with authority to influence change in order to deliver high standards of nursing care to the patient. The identity that forms is "Corporate Matron", a figure that is accepted, used and claimed by Matrons when it serves their professional project. However, perhaps this is a symbolic identity; Matron acting as a figurehead to affirm institutional discourse of "putting patients first" (DH, 2000) and "making a difference" (DH, 1999). I suggest that 'Corporate Matron' is a performance aimed at reconciling with the managerialist ideology of a performance-driven culture (Dent & Whitehead, 2002).

A closer analysis of the data reveals there are relational differences (Rattansi & Phoenix, 2005) between the corporate "front of stage" performance and individual performances within the directorates, relational difference between self (I) and collective (We) identities (Brewer & Gardner, 1996). The data has shown the Matrons working in a complex world of ideological tensions, spanning occupational boundaries and enacting

multiple identities across organisational levels. The Matrons individually and collectively shift between conflicting principles: they actively resist and embrace the didactic authoritarian rule of traditional Matron as required to fulfil their professional mandate; they are both authoritative and subordinated in their occupational relations with others; they promote the managerialist discourse of performance audit whilst prioritising an ideology of professional vocational care; they exist in their role as products of the professionalisation project in nursing, whilst expressing concern at a perceived loss of care from nursing as a result of that project. How then do the Matrons manage these dynamic and conflicting interplays to reconcile themselves in their role?

The following chapter articulates these findings into a culminating discussion of the main thesis where I argue that Essence of Care, a managerial device seeking to assess and monitor professional competency and performance appeals to the ideological foundation of nursing, the principle of caring for the patient (Bolton, 2003; Currie et al., 2009; Hewison, 1999). The Matrons embrace Essence of Care as it discursively mediates (Liaschenko & Peter, 2004) between their multiple role identities as professionals, managers and managing professionals (Causer & Exworthy, 1999). I use the term **syncretic action** to describe how, through Essence of Care, the Matrons are able to unite the contradictory and divergent beliefs and in doing so, ultimately constitute themselves in their role.

9 CONCLUDING DISCUSSION: Constituting Modern Matron through syncretic action

The previous three chapters have presented the interview data of sixteen Modern Matrons and one Senior Director working within an English NHS Trust depicting the complex and multifarious nature of their work and organisation as they negotiate their position, role and identity through individual, collective and discursive acts. This chapter provides a synopsis of the findings and leads to the culminating discussion of my thesis.

The research has been conducted within the context of nursing in the English NHS; an organisational setting which is institutionally and politically complex characterized by continually shifting organisational boundaries, roles and work practices (Dent et al., 2004; Halford & Leonard, 1999). The focus of the research has been the enactment of the Modern Matron role in a contested terrain of differing ideologies and blurring of organisational and occupational boundaries.

Methodologically, this research is located within a social constructionist paradigm where identities are perceived to be dynamic, relational and discursively constructed and where roles derive from individual and collective agency, performed through social interaction, mediated by organisational structure and communicated through language and discourse. I draw from theories on identity in my analysis of the data, with particular focus on dynamics of role relationships (Brewer, 2001); relational identity construction (Sluss & Ashforth, 2007); collective action (Ashforth & Mael, 1989; Cerulo, 1997) and discursive performance between individuals, others and organisation (Ainsworth & Hardy, 2004; Broadfoot et al., 2004).

The research contributes to a small but growing body of critical literature on the role of the Modern Matron within the English NHS. Studies on role and identity are of particular interest in contemporary health management as continuous reform has led to shifting perceptions and realities of what it means to be a health care professional (Currie et al., 2010; Lane, 2006); this research considers the data through a relational perspective on identity construction, hitherto under-explored (Sluss & Ashforth, 2007) thus adding to this field of knowledge. In this concluding chapter, I explore the manner in which Modern Matrons as hybrid professional-managers mediate between a duality of

professional and managerial ideologies. I argue that despite their managerial turn Modern Matrons do not assimilate into the dominant culture of performativity (Dent & Whitehead, 2002), rather they embrace the divergent ideologies through a process of **syncretic action**, discursively mediated by the policy initiative, Essence of Care.

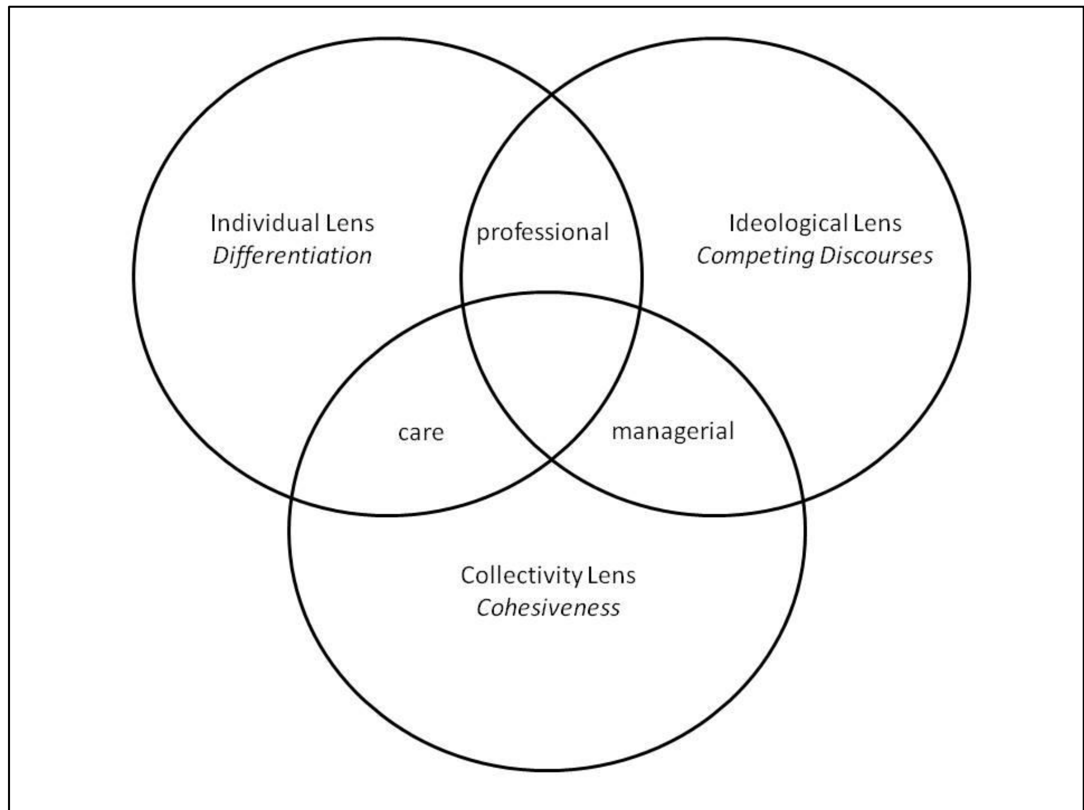
This chapter begins with a synopsis of the previous three findings chapters which build the line of argument for my thesis. I then discuss the concept of performativity in relation to my data and introduce syncretic action as an alternative original interpretive concept. I go on to explain this contribution in terms of the definition of term; its derivation and adaptation from anthropology, and its application to organisational research through an exploration of my findings. My concluding thoughts define my thesis and contribution to knowledge.

9.1 Findings Synopsis

The data has been drawn primarily from individual accounts of self, role and action as the respondents talk about their work; policy documentation and research notes provide further material which have also informed the analysis. As previously mentioned (Section 5.6, p.107), the emergent data has been organized with reference to a heuristic framework (Exworthy & Halford, 1999) which accommodates inter-relational analysis of identity through dimensions of collectivity, the individual and ideology. The findings from the data align with this framework as illustrated in Figure 9.1:

Figure 9.1: Inter-relational Framework

(adapted from Exworthy & Halford, 1999)



The individual lens is characterised by differentiation as revealed through ideological discourses of care and professionalism; meanwhile the collectivity lens is characterised by cohesiveness and influenced by ideological discourses of care and managerialism. The inter-relations between these dimensions will now be discussed.

9.1.1 Modern Matron through an Individual Lens: differentiation

The data analysis has presented a story of the inception and establishment of Modern Matron, a 'new' senior nursing role in an English NHS Trust. It describes a previous incarnation of the role, traditional Matron, as a senior authoritative figure which contemporary policy rhetoric seeks to revive; the role is situated in socio-political and historical discourse of ensuring high standards of cleanliness, managing infection control and maintaining order within the nursing domain, to ultimately deliver high quality

patient-centred care. The data suggests that whilst traditional Matron exists in rhetoric, the Modern Matron is not a singular, unitary and homogenous role; it is highly differentiated both intra-occupationally and inter-organisationally.

The organisational directorate structure accentuates this individuality, based upon strong allegiance to clinical specialty, within which role and identity is constructed through personalized relationships deriving from professional status as nurse; the business of management is rejected in favour of professional values underpinned by an ideology of patient-centred care. The Matrons insist on their individuality and autonomy within their directorates, they perceive themselves to be unique and different from one another in the way they each perform the role of Matron. By arguing that their role has changed in title only, they resist organisational influence and external control. Enacted at the directorate level of organisation, this is an identity that is relational and person-based (Brewer, 2001; Sluss & Ashforth, 2007), informed by their personally held values, beliefs and priorities, underpinned by a professional nursing ideology of vocational care-giving (Fagermoen, 1997; Taylor, 1997; White, 2002). Here, Matron provides strong leadership for nursing staff within the clinical specialty delivered through a discourse of occupational professionalism where power and authority is earned through demonstration of clinical experience and knowledge and reliant on building relationships through loyalty and trust (Evetts, 2005).

9.1.2 Modern Matron: discursive performance

The assumption of authoritative command and control in policy rhetoric and the historical legacy of traditional Matron are however undermined by discursive acts of authority and power relations between Matron and other professionals, across occupations. Here, Modern Matrons face contradictions between policy and action; with a corporate remit to implement managerialist policies to improve quality of care across occupational and organisational boundaries, they struggle to assert their power and authority beyond the nursing domain and are thus undermined in the role. This is ostensibly a nursing role within a medical hegemony and as such is constrained within the very boundaries it is expected to cross (Currie et al., 2010; Meulenbergs et al., 2004; McMurray, 2010, Taylor and Hawley, 2010). This is problematic when trying to

discharge their corporate duties of policy implementation; instead of command and control authority, the individual Matrons have to employ strategies of influence and negotiation to engage with other occupational groups (Currie et al., 2010; Meulenbergs et al., 2004; McMurray, 2010). Here, the Matrons are heteronomous rather than autonomous agents (Dent, 2003).

9.1.3 Modern Matron through a Collectivity Lens: cohesiveness

Meanwhile, through collective action, the Modern Matrons work together to present a cohesive corporate identity as professional-managers; they align themselves with the traditional stereotype of Matron and embrace managerialist policy in the shape of Essence of Care to affirm themselves in their role. "Corporate Matron" is a construct of organisational professionalism working within a discourse of control and authority along principles of accountability, externally managed from above rather than through collegial professional authority managed from within (Evetts, 2005). There is a natural tension between the managerial discourse of efficiency and performance and professional nursing ideology of vocational care-giving (Dopson, 1999).

9.1.4 Modern Matron through an ideological lens: competing discourses

The data reveals competing ideologies as enacted through the multiple social identities of Matron. At the level of individuals, working in their own directorates, Matron relates to a professional ideology of occupational professionalism, status conferred through knowledge, expertise, loyalty and trust. As individual nurses, they all subscribe to the ideology of vocational nursing care. Meanwhile, acting collectively, Corporate Matron identity adheres to a managerialist ideology, embracing institutional discourses of improving quality, patient-centred care and performativity. This reading of the data presents the Modern Matron role as contradictory, dynamic and contingent; a site through which numerous and competing discourses converge, are interpreted and enacted through the construction of multiple identities. These identities reflect the dynamic social processes of identity construction in the unpredictable and complex work environment of the English NHS and demonstrate relational elements of power and

resistance as individuals negotiate their role and situate themselves in the workplace (Mackey, 2007).

A reading of the literature would suggest that these ideologies are in conflict, for example, taking managerial decisions which affect direct patient care (Dopson, 2009) but, contrary to what might be expected, on the whole, the ideologies discursively reflected through the multiple identities of Matron, appear to have congruence with each other. Take as an example, policy discourse to deliver patient-centred care (DH, 2000), reflecting a managerial agenda to democratize the relationship between professional nurse and layperson and hence directly challenge occupational professionalism (Evetts, 2005); for the Matrons, this discourse directly aligns with the fundamental ideological nursing principle, to care for the patient, thus reconciling the ontological "I" of self (Dent & Whitehead, 2002) with the overall managerialist agenda of reform in the NHS. This is the essence of the hybrid professional-manager (Exworthy & Causer, 1999); the data shows the Matrons performing within and between boundaries, articulating contradictions and tensions in their collective and individual performance as they position and configure the Modern Matron role. The question that arises is how do they do this?

9.2 Constituting Modern Matron: structure and agency

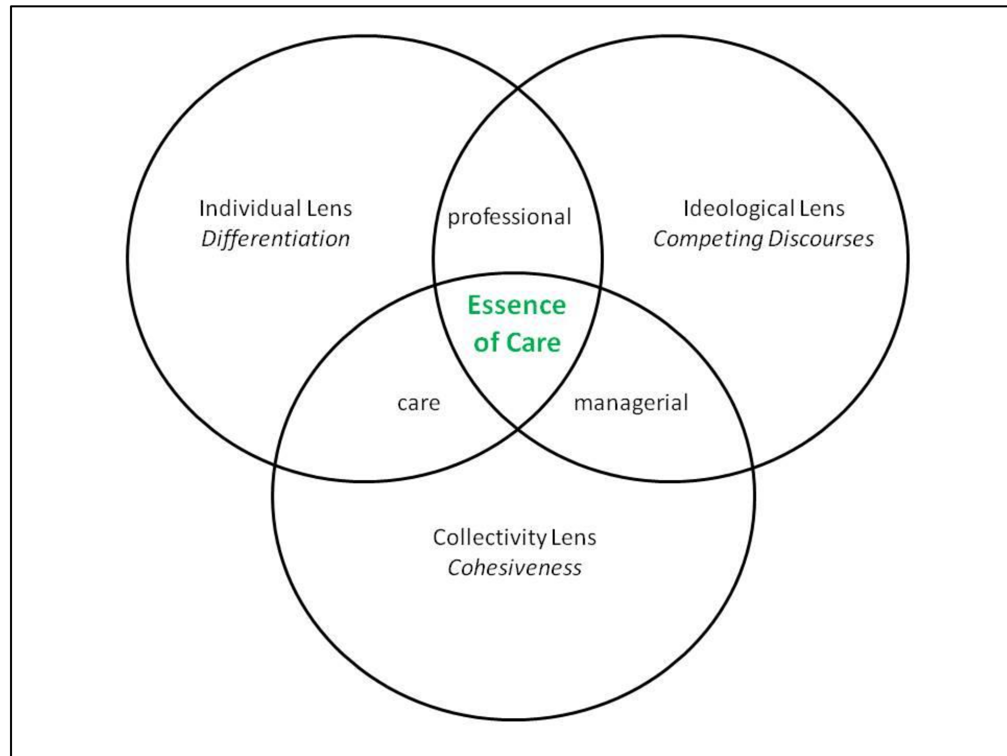
My assertion is that, in response to the ideological crisis of perceived loss of care in nursing, at a time when they need to be seen to act, the Matrons take ownership of, and responsibility for, Essence of Care, using the managerial device to support their professional mandate (Bolton, 2003; Currie et al., 2009; Dent et al, 2004); "colonizing" (Dent & Whitehead, 2002) and "corrupting" (Lozeau et al, 2002) it in order to take control of the ambiguities and contradictions they experience in their performance of the role.

From my discussion of the research data, I argue that conveyed through a policy discourse of holistic 'patient centred' care, the managerialist policy initiative of Essence of Care has immediate currency with professional nursing ideology and, as such, becomes integral to the social construction (Lozeau et al., 2002) of the Modern Matron

role, across the three dimensions of individual, collective and ideological discourse. This is illustrated in Figure 9.2 below:

Figure 9.2: Inter-relational Framework with Essence of Care

(adapted from Exworthy & Halford, 1999)



Following the literature that professionals use and rewrite scripts to reconfigure their roles and identities (Dent & Barry, 2004; Hotho, 2008, Whitchurch, 2008), I argue that Essence of Care acts as a discursive, mediating text (Liaschenko & Peter, 2004) through which to constitute the role of Modern Matron.

9.2.1 Essence of Care: a mediating text

As described earlier (Chapter 3) across the professional identity literature there is a growing consensus that professionals interpret, rewrite or reconfigure (Dent & Barry, 2004; Hotho, 2008) their roles in order to adjust to the new managerialist regime. In relation to the prevailing discourse of health reform, the focus has been on how reform

policies at macro-level (Government) are ‘translated’ at the micro-level of organisation (front line); indeed it was this very question that prompted this research, how Modern Matrons make sense of Essence of Care benchmarking. The process of policy implementation is imbued with meaning (Pope et al., 2006) derived from personally held beliefs and values; the extent to which policy is enacted at micro level is dependent on the degree of congruence between role, policy intention and these personally held values (Bolton, 2003; Hewison, 1999). This aligns with identity theory which argues for the dynamic interplay between internal self and society (Brewer, 2001; Stryker & Burke, 2000). Liaschenko & Peter (2004) in their discussion of challenges within contemporary nursing, speak of relational dynamics between professional practice and institutional control as mediated by texts, for example, standardized care maps and best practice guidelines. This has resonance with my research; Essence of Care is a text, promoting standards of best practice which mediates between professional practice, underpinned by a moral code of altruism, and institutional managerialism.

At an ideological level, Essence of Care offers discursive association between the external social environment and inner self; a vehicle through which to promote ideological values of patient-centred care (Hewison; 1999) and legitimise the inherent ontological beliefs of self as nurse (Dent & Whitehead, 2002) enabling the process of self actualisation (Halford & Leonard, 1999). Within individual directorates, Essence of Care is used as a communication tool through which Matron can address the perceived “loss of care” inherent to current nursing practice. The Matrons “colonise” the benchmarking process (Dent et al., 2004), that is, they take ownership of the principles to uphold basic standards of care, interpreting Essence of Care as a training aid through which to reinstate the caring ideology of nursing with staff in their clinical area. At a corporate level, Essence of Care is a script through which to turn political rhetoric about the Matron role into practical reality. The collective action to devise and implement a Trust-wide benchmarking process endows the Matrons with professional credibility in a culture of performativity (Dent & Whitehead, 2002).

9.2.2 Working within a 'Culture of Performativity'

Dent & Whitehead (2002) use the term performativity in the Lyotardian sense of commodification of knowledge and legitimization of science taking precedence over subjective knowledge forms. They relate this directly to managing professional identity and the issue of conflicting ideologies of managerialism and professionalism whereby the traditional mores of professionalism (expert knowledge; exclusivity; autonomy) are challenged by managerialist approaches which undermine professional knowledge (Sehested, 2002). Their intended use of the term is to describe the process by which professionals reconfigure themselves towards a "new professional" identity by assimilating with the prevailing managerialist culture of "technocratic rationality" (ibid. p.2). The precept is that as managerialism has pervaded public management, so too has "a belief in the veracity of objective systems of accountability and measurement rather than knowledge and judgment of the individual; professionals now have to earn trust and respect on their ability to "perform" to an externally given set of performance indicators" (ibid. p.2). By co-operating with managerialist systems of performance management, professionals demonstrate themselves to be acting professionally in a reconfigured notion of what being professional means; this interpretation of performativity resonates with my research.

The Modern Matron assumes a hybridized professional-manager role (Exworthy & Causer, 1999; Savage & Scott, 2004) with immediate exposure to the dialectic between professional and managerial ideologies. A key part of their remit is to monitor standards of cleanliness and care through managerial devices such as clinical benchmarking, Essence of Care. It is my assertion that the Modern Matrons, through their collective action on implementing Essence of Care, are working within the "culture of performativity", fulfilling their corporate remit by adhering to a managerialist philosophy of audit and control of professional work. In doing so, the Modern Matrons legitimize themselves in their role within the organisation; they have a visible presence and are working to a clear policy agenda which bestows credence to their position and presence in the nursing hierarchy.

As has been noted (Section 3.3.4, p.59), the Modern Matron works within the constraints of managerial and medical hegemonies where it is difficult to attain the requisite power

and authority to enact the 'senior authoritative lead' of traditional Matron as assumed by policy rhetoric (Currie et al., 2009; DH, 2001b); I argue therefore that the Modern Matrons are embracing managerialism in the form of Essence of Care, actively choosing to work within the culture of performativity rather than resist it, to gain power and status within the organisation; after all, this is a newly conceived role which the respondents have to establish and in doing so, construct their role and associated identity within it. McMurray (2010) refers to a similar concept, 'professional entrepreneurialism' as a way by which senior nurses acting within the medical hierarchy positively use managerialist discourse to take control of service delivery and gain authoritative power based on their managerial performance as 'professionalised' nurses.

The above concepts have significance in relation to the findings from my data and are useful to help explain how and why the Modern Matron identity is discursively constructed; however, within these texts, there is an assumption that the professional moves away from their professional ideology and values towards the managerialist discourse with the implication that their professional identity is subsumed and reconfigured within the managerial hegemony; the commonly applied term "hybrid manager" aptly illustrates this point.

Dent & Whitehead (2002) present performativity as managerial ideology *in contest with* professional ideology; that professionalism is "*replaced*" (ibid. p.2) by the culture of performativity; that professional identity is "*subsumed"* within a dominant culture of managerialism (ibid. p.3) and that the professional must "*succumb*" (ibid. p.8) to pressure for performance measurement, taking their place "*within"* the scientific knowledge order that is managerialism (ibid. p.9). Their argument holds that the professional-managerial configuration comprises many dualities and tensions which the professional has to mediate and negotiate as ultimately, "there is no uncontested ideological position to which they might retreat" (ibid. p.5). In similar vein, O'Connor (2008) argues that vocational care in nursing has been marginalised within the technical rationalism of managerial professionalism. My data offers an alternative perspective; the Matrons positively embrace managerialism through Essence of Care whilst equally maintaining and upholding their professional nursing values.

My contribution to the discussion of professional identity within health care management is to argue that *there is* an uncontested ideological position which acts to unite the perceived tensions and dualisms between professional and managerial aspects of the Modern Matron role. The ideology of nursing as fundamentally about vocational care-giving and looking after the patient (Fagermoen, 1997) is a persistent and recurrent discourse within the data. This is at the core of each individual Matron, the motivating force behind action. The individual nurse identity reveals deep-seated values of care-giving, guided by moral and ethical principles of person-centred care. This is the professional nurse, emotionally connected and motivated to the vocation of nursing, above all else. Mackey (2007) talks of the professional gaze of autonomous action, self discipline which creates a discourse of professionalism – in the case of the Matrons, this discourse revolves around cleanliness and patient-centred care.

The collective corporate identity whilst overtly managerialist in both political remit and action taken, is also based upon a discourse of improving the quality of patient-centred care; there is no argument from the Modern Matrons about this; in fact they positively agree with the fundamental tenet of political discourse (Section 6.1.3, p.116). Whilst in other professional arenas, the customer focused aspect of new public management approaches to service delivery may be problematic (Dent & Whitehead, 2002), in the case of the Modern Matrons interviewed, this was not an issue; the ideological premise of nursing care centres upon altruistic values to care for the patient; the patient is already centre stage in the Matrons' personally held beliefs. To be asked therefore to put the patient first, and implement managerialist devices (clinical benchmarking) to help achieve this, is not contestable. There is no underlying threat to their nurse identity and as such, I argue that, in the case of the Modern Matrons in this research, they positively embrace Essence of Care as a managerial device which works with, rather than in opposition to, their professional ideology.

This is not to say that tensions do not exist within their role; the data shows that they do, but I argue that such tensions are mediated through the relational nature of identity constitution; the Matron as "all and everything", moving within and between differing discourses, negotiating self in relation to other in a highly dynamic and contingent way.

I argue that the Matrons use Essence of Care to embody all three discourses, a process of syncretic action which in turn, constitutes the Modern Matron role.

9.2.3 Syncretism

Syncretism is an anthropological term which describes the blending together of divergent cultural and ideological systems. It refers to the combining of elements from multiple traditions, ideologies or belief systems (Stewart, 1999); syncretism is more specifically used in the study of religion to describe "the continually contested social action which, operating across cultures and traditions, appropriates, reproduces or reinvents religious belief and practice" (Werbner, 1994, p.201). An example of a syncretic religion is Umbanda, an Afro-Brazilian religion which blends elements of Catholicism, Spiritualism and African (Yoruba) religion together to create a unique religion, specific to time and place and rooted in cultural identity (Dann, 1979). It is argued that Umbanda emerged in urban areas of Brazil as a "remedy to the imbalance of social justice" (ibid. p.214) for a population experiencing social and racial discrimination, incorporating the most appropriate elements from each religion (for example, ritual and magic) to engender a sense of power and control for individuals performing within "a context of urban powerlessness" (ibid. p.220).

Werbner (1994) writes of the agential aspects of syncretism, whereby difference and identity are actively and flexibly reworked to be "definitive of the self in contrast to the Other" (ibid. p.202) thus locating the term firmly in the social constructionist paradigm in relation to identity construction. In the case of Umbanda, its followers have chosen elements from each of the three religions which align with their deeply held cultural values to form a "unique and dynamic" religious identity, the "umbandista" (Dann, 1979, p.221). This identity provides a spiritual code for living "whatever the meaninglessness of his surrounding society" (ibid. p.212).

In anthropological texts, syncretism has been heavily criticized as a pejorative term which presupposes homogeneity and purity of the original cultural or religious elements which are combined, with the negative implication that the syncretic mix is inferior (Stewart & Shaw, 1994). However, from a critical perspective, it is argued that cultures

and religions are not fixed entities, rather they are constructed and performed discursively; with this theoretical frame, syncretism has reappeared as a means by which to "focus on dynamic intercultural and intracultural transactions" (Stewart, 1999, p.55). Stewart (1999) observes that syncretism is the process by which cultures are constituted and that this is contingent, temporal and derives from historical and socio-political events. This has resonance with the critical turn in identity studies, identity formation as transient, contingent and discursively created (Alvesson & Karreman, 2000; Cerulo, 1997) and thus has relevance to my research.

Hasselbladh & Selander (2003) in their discussion of professional identity in nursing homes in Sweden explore how work and identity are constituted through "plural frames" of professionalism and new managerialism. Pluralism has similarity with syncretism in that it describes multiple elements in juxtaposition however, as discussed by Stoner (1986) in his paper on syncretic medical systems, these pluralistic elements remain in parallel, separate and distinct from one another. Syncretism describes a blending of distinct elements, to create a combination unique to that situation. Blending is referred to by Hasselbladh & Selander (2003) but in terms of blending professionalism within the new managerialist paradigm, similar to Dent & Whitehead's (2002) culture of performativity whereby professional elements are subsumed within dominant managerialist discourse (ibid. p.3); Stoner (1986) argues that syncretic blending does not give preference to one element over another, rather elements from all plural frames are selected on the basis that they best serve the individual or collective mandate; in his example, a midwife uses a combination of folk tradition, biomedical practice and shamanism to offer a pluralistic service with which to best serve the diverse community in which she practices. The point of interest here is the emphasis on drawing from all elements rather than assimilating practice into one plural frame over another. Stoner (1986) does not relate his discussion of syncretism of midwifery practices to the concept of identity construction; however I believe it has relevance and take the idea further to argue that syncretism presents a useful alternative lens through which to consider the 'performance' of role and identity construction, thus bringing performativity and syncretism together for an understanding of the processes by which Modern Matron is constituted.

A literature search of key management databases suggests that “syncretism” is not a term widely used in management texts. There are a small number of journal articles which use the term as a synonym for ‘synthesis,’ ‘combination’ or ‘hybridization’ in relation to broad managerial principles of partnership working and strategic alliance (Appendix M); however, this is descriptive terminology. Syncretism has deeper foundations as a process of sense-making (Berk & Galvan, 2009) and it is this meaning that I draw upon in my analysis.

I understand syncretism to be the process by which, through transformative agency, individuals singularly and collectively draw from and act upon multiple and diverse elements in the creation of new identity(ies) in response to their dynamic and inter-relational social environment. In the case of the Modern Matrons, institutional reform has led to restructuring and reorganisation of work practices and roles; to make sense (Weick, 1995) of the complex and variable organisational terrain, the respondents have selected aspects of different discourses to constitute themselves in their role. Whereas this might at first appear as contradictory subordination of one discourse (professionalism) into another (managerialism), I argue that this is not the case. Rather than making a choice to assimilate into managerialist hegemony, the respondents positively select and harmoniously maintain aspects of their professional, managerial and self identities. They do this through a medium of policy implementation, acting on the policy initiative Essence of Care, and through individual and collective interpretations, interweave elements from divergent discourses and thus make sense of their role and identity within the organisation; this process I have termed syncretic action.

In my review of the literature, there is one recent article that has salience with my understanding of syncretism and conceptualisation of syncretic action. Berk & Galvan (2009) present the case for “creative syncretism” in understanding agency in institutional change. They argue from an institutional perspective, believing that structural disorder offers opportunity for innovation and creativity; creative syncretism describes how individuals respond to this opportunity by “looking back to the intimate knowledge they have of the parts of the organisation and recombine these parts to cobble together a novel response to a new problem” (ibid. p.550) suggesting a syncretic perspective offers

"a new terrain for an invigorated understanding of agency within and on institutions" (ibid. p.577).

Berk & Galvan (2009) contextualise syncretism as an appropriate perspective for analysis of sense-making, agency and institutional change in relation to American political reform, emphasising the transformative agency of the individual in adapting to change. To my knowledge, there have been no attempts to explore the performative aspects of role and identity construction through the lens of syncretism; my thesis on the constitution of Modern Matron through syncretic action hence offers an original contribution to knowledge.

9.2.4 Implementing Essence of Care: syncretic action

The health care management and professional identity literature infers contradictions and tensions between professional and managerial ideologies and these are also reflected in the data from the Modern Matrons; however, it does not appear that these tensions are regarded as overtly problematic rather the respondents seem to accept divergence and contradiction as integral to the role. I argue that the Matrons in the study, individually and collectively, use Essence of Care as a vehicle through which to syncretise divergent elements and in doing so, constitute themselves in the role.

Essence of Care is founded upon principles of patient-centred nursing care, an ideology that resonates deeply with the nursing values that each individual holds. It offers a way by which to address the perceived "loss of care" in nursing and thus redress the balance between vocational and professional nursing. The initiative also embodies the technical rationality of performance management, aligning with policy rhetoric and the respondents collectively use it as a way by which to legitimize the Modern Matron role in the organisation and beyond, as illustrated by the kudos attributed to conference and media attention on their work with Essence of Care.

Essence of Care enables the respondents to be visible, to both staff and patients; the respondents selectively choose to draw from the archetypal image of traditional Matron as the standard-bearer for cleanliness in their interactions with these groups. In their inter-relations with medical colleagues, the respondents do not challenge their

heteronomous status rather they ‘colonise’ the benchmarking process, taking ownership of it as something which rightfully belongs in the nursing domain and by doing so gain some control and autonomy over their work (Dent et al., 2004). Within their directorates, as individuals, the respondents use their professional credentials to gain authority with which to fulfil their clinical leadership remit and use Essence of Care as a communication tool with nursing staff.

The respondents positively embrace Essence of Care as it enables them to seamlessly blend the professional, managerial and nursing elements in the performance of the Modern Matron role and thus respond to the multifarious expectations and demands place upon them; through Essence of Care, the respondents actively select and choose the elements of the various discourses that help them perform their role without prioritising one over the other and without threat to their deeply-rooted personal values and status as nurse, professional or manager. This illustrates agency in syncretic action by which role and relational identities are formed.

The Modern Matron role is contingent on socio-political and historical events, a construction of a time and place; situated and relational, formed through interactions between individual Modern Matron and “Other” by spanning boundaries of self (I) and collective (We), across organisational structure and between occupational groups. Policy discourse is frequently changing (Walshe, 2010) and as Essence of Care melds into the policy background, so the role configuration of Modern Matron will change; syncretism offers a useful way by which to understand the process of social identity transformation which moves beyond contested dualisms.

This research offers a timely contribution to a nascent body of knowledge on the concept of syncretism as an analytical lens in contemporary health care management. I argue that syncretic action offers an alternative perspective through which to understand the reconfiguration of hybridized professional-management identities in public management and the wider field of organisation studies.

9.3 Further Considerations for this Research

In the process of writing this thesis, I recognize there are areas that are worthy of further consideration. The first and most obvious of these is to explore further the concept of syncretic action with regard to understanding role transformation and relational identity in public management, and my specific area of interest, health care management. The concept has wider implications for identity studies at the micro level of individual, an area currently under-researched (Currie et al., 2010). There are also implications for policy in terms of nursing education and human resource strategy for introducing new roles within established organisational hierarchies.

I would also wish to conduct research into the nature of relational identity and role-relationships through multiple perspectives of the many actors involved in the social identification process; the singular focus on the Modern Matrons in the case organisation has been a limitation in this sense.

Having not originally set out to undertake a study of professional identity, and with the benefit of hindsight, I would ensure that further research into relational identity construction would take a creative, multi-method approach by which to elicit in-depth accounts of "lived experience" within a longitudinal ethnographic study, allowing for a greater depth of understanding of the deep-seated values and beliefs which are the essence of identity construction.

A second area for further exploration is the performance of gendered identity in feminised occupations through in-depth analysis of the gendered discourse which weaves through the data; in particular, the relationship between masculine femininities and feminine masculinities in role performance (Pullen and Simpson, 2009).

Finally, a question that remains unanswered is whether the emphasis on the ideology of nursing care as essential to self as nurse, as well as to individual and collective Modern Matron identities in this research, is indicative of a reversion from "professional nurse" to nursing as a vocational occupation?

Appendix A: Conference Paper Abstract

Paper presented at the Gender Work & Organisation Conference

June 2010, Keele University, UK

Exploring policy implementation through gendered identity and discourse: Modern Matrons, Essence of Care and NHS Reform

Liz Matykiewicz & Lynne Baxter

The York Management School, University of York

Abstract

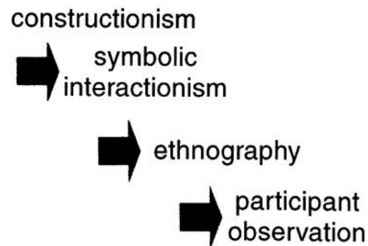
This paper reflects the voices of Modern Matrons in the UK National Health Service (NHS) as they talk about their work, a combination of clinical and managerial tasks performed within a complex organisational and political landscape, and how this ‘talk’ emerges values and feelings held about nursing as a profession and the fundamental task of care-giving. The qualitative data reveals an emotive response to the need for policy to address a perceived gap in provision of basic nursing care. It provides an opportunity to contribute to the body of knowledge on gendered identity through critical analysis of the Modern Matron role and its incumbents, as individuals and collectively; how they identify themselves and their responsibilities and how they reconcile the complexities and contradictions in their work.

Appendix B: Example of Methodological Choices

Crotty (2003) illustrates the range of theoretical paradigms, methodological approaches and methods that are available to qualitative researchers; he emphasises that this is a representation of possible options, not a definitive list and argues for pluralistic, multi-method combinations between the categories listed:

Methodological Categories (Crotty, 2003, p.5)

Figure 2



methods. An attempt to list a representative sampling of each category might result in something like Table 1. (But note the several 'etceteras' occurring in this table. It is not an exhaustive listing.)

To denote another typical string, an arrow could start with 'objectivism'. Objectivism is the epistemological view that things exist as *meaningful* entities independently of consciousness and experience, that they have truth and meaning residing in them as objects ('objective'

Table 1

Epistemology	Theoretical perspective	Methodology	Methods
Objectivism Constructionism Subjectivism (*and their variants*)	Positivism (and post-positivism) Interpretivism • Symbolic interactionism • Phenomenology • Hermeneutics Critical inquiry Feminism Postmodernism *etc.*	Experimental research Survey research Ethnography Phenomenological research Grounded theory Heuristic inquiry Action research Discourse analysis Feminist standpoint research *etc.*	Sampling Measurement and scaling Questionnaire Observation • participant • non-participant Interview Focus group Case study Life history Narrative Visual ethnographic methods Statistical analysis Data reduction Theme identification Comparative analysis Cognitive mapping Interpretative methods Document analysis Content analysis Conversation analysis *etc.*

Appendix C: Methodological Choices in Health Care Literature

Health Care Literature: Examples of Methods Used

Author(s)	Date	Title	Approach	Methods	Analysis	Publication
Ainsworth, S., Grant, D. & Idema, R.	2009	'Keeping things moving': space and construction of middle management identity in a post-NPM organisation	Case Study	Interviews	Discourse analysis	Discourse and Communication 3 (5)
Currie, G., Koteyko, N. & Nerlich, B	2009	The dynamics of professions and development of new roles in public services organisations: the case of Modern Matrons in the English NHS	Case Study	Interviews	Thematic analysis	Public Administration 87 (2)
Currie, G., Finn, R. & Martin, G.	2010	Role transition and the interaction of relational and social identity: new nursing roles in the English NHS	Longitudinal Case Study	Interviews	Thematic analysis	Organisation Studies 31
Sobo, E., Bowman, C. & Gifford, A.L	2008	Behind the scenes in health care improvement: the complex structures and emergent strategies of implementation science	Case Study	Interviews Participant Observation	Textual analysis	Social Science and Medicine 67
Bolton, S	2004	A simple matter of control? NHS Hospital Nurses and New Management	Longitudinal Study	Interviews Observation	Thematic analysis	Journal of Management Studies 41 (2)
Ohlen, J & Segesten, K	1998	The professional identity of the nurse: concept analysis and development	Fieldwork	Interviews	Open Coding	Journal of Advanced Nursing 28 (4)
McMurray, R.	2010	The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners	Ethnographic Case Study	Interviews Observation	Qualitative analysis	Human Relations XX (X)

Apesoa-Varano, E.	2007	Educated caring: the emergence of professional identity among nurses	Ethnographic Case Study	Interviews Observation	Thematic analysis	Qualitative Sociology 30 (3)
Sambrook, S.	2006	Management development in the NHS: nurses and managers, discourses and identities	Case Study	Interviews	Discourse analysis	Journal of European Industrial Training 30 (1)
McDonald, R.; Rogers, A. & Macdonald, W.	2008	Dependence and identity: nurses and chronic conditions in a primary care setting	Case Study	Interviews	Thematic analysis	Journal of Health Organisation and Management 22 (3)
Allan, H.T. & Smith, P.	2005	The introduction of Modern Matron and the relevance of emotional labour to their roles: developing personal authority in clinical leadership	Case Study	Interviews	Thematic analysis Narrative analysis	International Journal of Work Organisation and Emotion 1 (1)
Ashman, M., Read, S., Savage, J. & Scott, C.	2006	Outcomes of Modern Matron implementation: Trust nursing directors' perceptions and case study findings	Case Study	Questionnaires Interviews	Thematic analysis	Clinical Effectiveness in Nursing 9S1
Smith, A	2008a	Modern Matrons: reviewing the role	Case Study	Questionnaires	Thematic analysis	Nursing Management 15 (4)
Smith, A	2008b	Modern Matrons: reviewing the role	Case Study	Interviews	Thematic analysis	Nursing Management 15 (5)
Savage, J and Scott, C	2004	The Modern Matron: a hybrid management role with implications for continuous improvement	Case Study	Questionnaires Interviews	Thematic analysis	Journal of Nursing Management
McDonald, R	2005	Shifting the balance of power? Culture Change and Identity in an English health care setting	Ethnographic Case Study	Participant Observation Interviews Document analysis	Thematic analysis	Journal of Health Organisation and Management 19 (3)

Appendix D: Journal Article Abstract

The Emerald Research Register for this journal is available at
www.emeraldinsight.com/researchregister

The current issue and full text archive of this journal is available at
www.emeraldinsight.com/1463-5771.htm

Essence of Care benchmarking: putting it into practice

Liz Matykiewicz
Department of Management Studies, York University, York, UK, and
Dave Ashton
The Learning Alliance, Education Centre, James Cook University Hospital, Middlesbrough, UK

Abstract

Purpose – The purpose of this paper is to introduce Essence of Care, a benchmarking tool for health care practitioners and an integral part of the UK National Health Service (NHS) Clinical Governance agenda. It focuses on how one NHS Community Health Trust has attempted to introduce organisation-wide benchmarking by using a workshop programme to raise awareness and act as a catalyst to initiate implementation. An evaluation of progress made six months after the workshops were delivered is described.

Design/methodology/approach – The paper outlines the case study approach taken and describes the qualitative methods used in the small scale evaluation, namely interviews and focus groups with the decision makers and implementers of Essence of Care across the case study site.

Findings – The evaluation highlights that whilst raising awareness is relatively straightforward, putting Essence of Care into practice is more difficult to achieve, especially when happening at a time of significant organisational change. The discussion considers the need for a receptive context for change when implementing benchmarking for service improvement and reviews whether Essence of Care benchmarking could be a practical framework for developing an improvement culture within an organisation.

Originality/value – The empirical findings from this research will contribute to the knowledge and understanding of using benchmarking for service improvement within the NHS.

Keywords Benchmarking, National Health Service, United Kingdom

Paper type Case study

Introduction

Quality management is not a new phenomenon in the UK National Health Service (NHS). Clinical audit, performance indicators, standard setting, quality circles and patient satisfaction surveys are all examples of attempts to "manage quality" in the delivery of health care services (Morgan and Everett, 1990). NHS reform is a central aspect of the UK government's modernisation agenda for public services, introduced in the 1997 White Paper, The NHS; Modern, Dependable. The central message is that the NHS should provide high quality, patient focused care through improvement to organisational systems, structures and processes, supported by up to date technologies and more investment (Wistow, 2001).

The NHS has committed to improve quality of care for patients and emphasises the importance of "getting the basics" right to improve the patient experience (Department of Health, 1999, 2000). The NHS quality framework describes how quality standards are set and monitored at a national level and delivered at a local level, through three broad areas; professional self-regulation, lifelong learning and clinical governance

Benchmarking: An International Journal
Vol. 12 No. 5, 2005
pp. 467-481
© Emerald Group Publishing Limited
1463-5771
DOI 10.1108/14635770510619384

Appendix E: Letter of Invitation

Contact Address:

Dept of Management Studies

York University

Heslington

YORK

YO10 5DD

17 May 2005

Dear Participant,

Re: PhD Thesis: Quality Tools – context and impact: making sense of Essence of Care

I am undertaking PhD study in the field of quality management and in particular, quality improvement within health and social care.

My PhD research focuses on the implementation of Essence of Care benchmarking within the NHS. Your organisation has agreed to be the case study site for this research and I am writing to you to invite you to participate in this research.

During the following months, I would like to hold interviews with Modern Matrons who have been actively involved in the planning and implementation of Essence of Care benchmarking within your organisation.

During the interview process, you will be asked to reflect on your involvement with Essence of Care benchmarking, highlighting any critical incidents or key events that may have occurred and asked to share your personal account(s) of these.

The interview process will be split over two sessions, each lasting approximately one hour, to be arranged at a time and venue that is convenient to you. All information recorded about you during the course of the research will be kept strictly confidential

In accordance with research ethics procedures, please find enclosed a Participant Information Sheet outlining the purpose of the research and also a Consent Form, which you will be asked to complete in advance of participating in the research.

Participation is entirely voluntary. If you are willing and able to take part in this research, please can you let me know when you would be available for the first interview session either by returning the fax reply slip (attached); by email (lm514@york.ac.uk) or give me a ring on 07795 315038.

I look forward to hearing from you in due course.

Thank you and best wishes,

Liz Matykiewicz

Appendix F: Participant Information Sheet

You are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. *Thank you for reading this.*

What is the purpose of the study?

The research is being undertaken as the primary data source for PhD research. The main research question is: How are quality improvement tools applied in the health and social care sector and what is the interplay between the tools and the socio-cultural context into which they are implemented?

The aim of the research is to explore what happens when staff members are asked to use Essence of Care benchmarking in order to improve practice as part of the Trust's Clinical Governance agenda. The focus of the research is **how** staff members make sense of Essence of Care benchmarking and will explore questions such as: What does Essence of Care mean to people? What language do people use when describing Essence of Care? How is Essence of Care being implemented across the Trust?

Why have you been chosen?

The research is dependent upon the views and experiences of people who have been directly involved in planning, implementing and/or using Essence of Care benchmarking within your Trust. You have been chosen because of your involvement with Essence of Care benchmarking in your department/organisation.

Do you have to take part?

You are under no obligation to participate in this research. Participation is voluntary and it is your decision whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work in any way.

What will happen to you if you take part?

The research involves conducting one-to-one interviews with people involved in Essence of Care activity within the Trust. You will be required to give a few hours of your time to be involved in the data collection process. The researcher will contact you to arrange a convenient time and date for the interview. You will be asked to give your consent to be tape recorded during the interview.

What do you have to do?

As a participant, you should be willing to be interviewed. It is hoped that you would be prepared to share your views, opinions and experiences of Essence of Care benchmarking, candidly and honestly.

What are the possible benefits of taking part?

By participating in this research you will have an opportunity to take time out to reflect on your practice. The information gathered through this research may help staff and policy makers to better understand the benefits and limitations of Essence of Care benchmarking in practice.

Confidentiality

All information recorded about you during the course of the research will be kept strictly confidential and will have your name and address removed so that you cannot be recognised from it. All information recorded about you will only be used for the purposes of this research and will be filed securely for the duration of the research and archived securely thereafter. Only the researcher, research supervisory team and administrative staff involved in transcribing the data collected during interviews will have access to the research data.

What will happen to the results of the research study?

The results of this research will be published as a PhD thesis in 2009. It is likely that the results of the research will also be published through academic social science journals, conference papers and presentations. The Trust and research participants will receive a copy of a summary report highlighting the results of the research. Confidentiality will be maintained at all times and participants will not be identified in any report/publication.

Who has reviewed the study?

The research proposal has been reviewed and accepted by the Local Research Ethics Committee. The research supervisory team, based at York University is monitoring the research.

Contact for Further Information

If you have any questions or concerns about participating in this research, or for further information, please contact: Liz Matykiewicz, Department of Management Studies, York University, Heslington, York, YO10 5DD. Mobile: 07795 315038 Email: lm514@york.ac.uk

Thank you for taking part in this research.

Appendix G: Consent Form

I have a copy of the PARTICIPANT INFORMATION SHEET about the PhD research and I have had time to read it, and to think about what I have read. The research has also been described to me and I have been able to ask questions about it.

I understand that:

- The research concerns the implementation of Essence of Care benchmarking within my organisation and that my views and information about me are being asked for because I have been directly involved with planning, implementing and/or using Essence of Care benchmarking.

- I am not obliged to take part in the research study and if I do not take part, my work will not be affected in any way.

- I am free to change my mind at any time about participating in the research, without my work being affected in any way.

- I can ask not to be tape recorded during an interview and/or focus group.

- All information recorded about me will be used only for research and will be kept strictly confidential and will have my name and address removed so that I cannot be recognised from it.

- Information about me will be treated confidentially at all times; it will be kept secure and made available only to the research team.

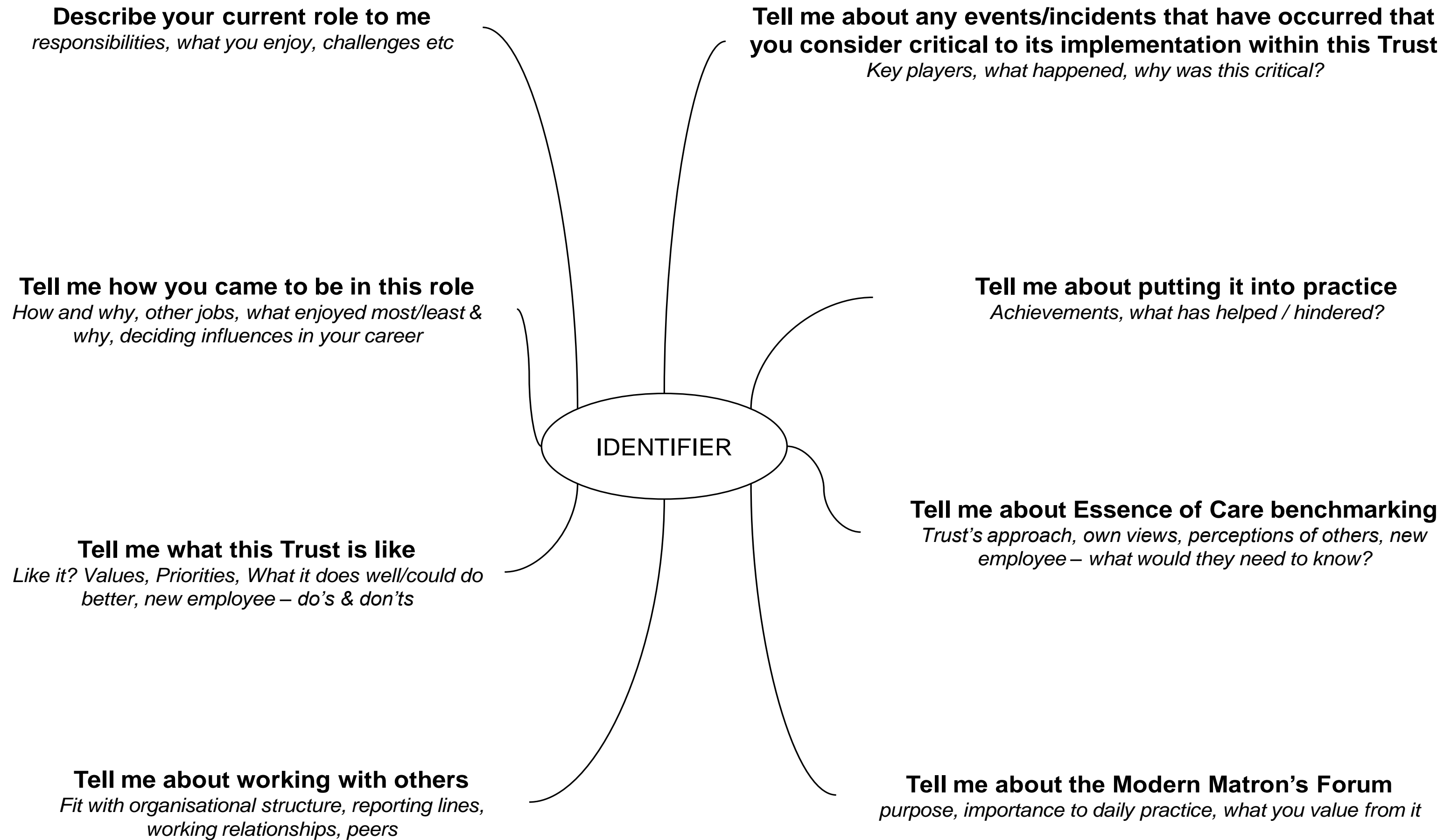
- Information will not be used in any way that will lead to my name being known without my express permission.

I agree to take part in the research study and answer some questions.

Name: ______________________________

Signature: ______________________ Date: __________

Appendix H: Interview Topic Outline



Appendix I: Example Transcript

MM06 – 11.08.05

LM: The first question is really if you could just describe your, your role to me and, and the kind of responsibilities that you have within that role?

MM06: Right .. I've actually be in post a year now so I'm fairly, I'm probably one of the newer matrons, I have to say, in the Trust, and I'm matron for Elderly Care. So that covers all of the Elderly Care roles across the [hospital sites]. So I have two wards here at [site x], 14 and 15, I have 14, 15 and 18 at [site y], which gets very complicated cos people say Ward 14, and you have to clarify whether it's 14 in [site y] or 14 [site x]. So I have 14, 15 and 18 at the [site y], and then I cover all of [site w], which is rehabilitation and intermediate care and continuing care wards down at [site w], and there's four wards down there, and also have the Falls and Syncope Service, which is at the [site y], and a Day Unit which is just here at the [site x] as you come in, which is the day hospital. So quite a huge area across three sites.

LM: And which directorate do you belong to?

MM06: Medicine, it's the Directorate of Internal Medicine, it's all under one umbrella, it's Directorate of Internal Medicine, Care of the Elderly and Accident & Emergency. So it's the hugest, it's the largest directorate in the Trust, so it's massive.

LM: And, and in terms of your, I suppose key responsibilities then covering all of that area, what are the sorts of things that…?

MM06: A lot of staff management, which is what I've been involved in this morning. .. Monitoring budgets, the systems, the budgets, a lot of .. recruitment, looking at retention, Improving Working Lives we're quite heavily involved with now. A lot of staff training, I get involved in quite a lot of training, and looking at standards really, standards of care, and complaints, quite a huge chunk of my work as well unfortunately and dealing with complaints. Oh the list is endless (laughter).

LM: And is it largely therefore non-clinical work that you do?

MM06: Yeah, when I first, when I came into post I desperately wanted the job to be more clinical than it is, I have to say. .. But I think, and I'm sure when you talk to some of the other matrons they're, they'll be much more clinical than I am. Because it's such a huge area I find that my clinical time is really quite limited, quite limited, and so, I mean I've been doing a lot of training down at [site w] and to me that's clinical, although I'm not actually on a ward dealing with patients, to me that's still quite a lot of clinical input, so to speak, cos it was very practical based training that I was doing. But it's not as clinical as I would have wanted it to be, I have to say. But I just, you know, it's very,

very difficult to find the time to actually go and work a shift on the wards. I have done it but it's been few and far between, you know, so.

LM: And in terms of the kind of, the relationships you've got with, I suppose what are the different reporting lines that are going on between yourself and, and all the different wards that you…?

MM06: Right, well they all have a ward sister, a G grade ward sister and, and most of them have an F grade but not all of them. So the G, the ward nurses would report into the G grades, the G grades would then report to me, if they felt it was necessary, or they would just deal with it themselves, depends on what the issue was really. The G grades would report in to me, I either then deal with it and, you know, that would be that, or I would then report it to my manager, who is nursing operations manager for the entire directorate. So she's got quite a massive job, so.

LM: OK, and is that the only person you report to?

MM06: Yeah, I would report in to her first. I mean there's our Heads of Nursing and, and yes I might sort of let them know what's going on if it was necessary, but my first line is [name], I report to [name] really.

LM: So that's actually a huge number of people?

MM06: Oh it's massive, it's massive. (laughs) Yeah, I mean eleven wards and departments all sort of reporting in to me with various things it's, yeah, it's massive, massive. And, you know, you have some areas obviously where some G grades are far more confident and capable than other areas, and sometimes, you know, they never bother me with, with problems that other wards might because they deal with it themselves and they don't feel they need to inform me and that's fine, you know, that's, I trust their judgement really. But I've got quite a lot of sort of inexperienced or sort of new in post G grades. So, I have to say, since I come into post there's been quite a lot of strife, you know, so there's been a lot to sort out and that, so.

LM: So in terms of how you did come to be a modern matron, what, what's the kind of route you've taken to get…?

MM06: In my career?

LM: Yeah, to get here.

MM06: Yeah, probably not like a lot of people actually, to be honest, in that I was staff nurse for years and years and years because I wanted to stay at home and look after me kids basically, and I worked two nights a week for about oh ten, twelve years, something like that, and I was very happy to do that because I was very much a mother and I wanted to be at home and, you know, it's all right saying that these days, but, you know, back then people frowned upon you. But I stayed at home and looked after the kids and

worked two nights a week, and then gradually when they sort of got to middle school age I started to think right time now to start looking at getting onto day shift and, and moving on a bit. Having said that, while I was on nights I did used to do quite a lot of study, when they were in school and stuff, it was much easier I have to say, and I did my diploma when I was doing two nights a week, cos I had the time to go to university and, you know, time to study really. .. So I started to go onto days a bit and I rotated, and then I got an F grade post, which was a junior sister's post on Orthopaedics, and that also incorporated night duty, which was looking after the hospital at night. But of course I've had years of night duty experience so that was fine. And then from there I moved into a nurse practitioner's job and I was working as a G grade nurse practitioner on Stroke and Care of the Elderly and I did that for three and a half years. Again it was still shifts, so still working Christmas Day and all the rest of it, and really I had decided, after twenty-eight years of being a nurse, I was a bit fed up of going to work on a Christmas Day. So .. this job was advertised in the local paper and I thought hey Monday to Friday. It was back being more nursified, if you see what I mean, cos working as a nurse practitioner is very much more a medical model, you know, I was working more or less like a junior doctor and I wanted to get back onto the nursing side, and for me this was an ideal opportunity. It was promotion, it was Monday to Friday and it was back with the nursing. Because in the nurse practitioner job I was .. a lot of time on nights and a lot of that was staff management and dealing with staff issues and stuff like that, and that's really what I really enjoy. So this was a natural step to come into this because it's a lot of staff management and a lot of like clinical issues and stuff, sorting all of that out, and that's what I like. So it was sort of financial progression, so.

LM: So how long have been in the matron post?

MM06: Just a year.

LM: A year.

MM06: A year past June.

LM: Yeah, yeah I'm trying to work out because as you talk to different people…

MM06: I know, you forget. (laughs)

LM: …different people come in at different stages.

MM06: That's right, yeah.

LM: Some people have been rebadged, some people…

MM06: Yeah.

LM: …have actually gone for, to advert and applied.

MM06: Well I came in via the local paper (laughter) and new to the Trust as well.

LM: OK.

MM06: Because I hadn't worked in this Trust at all and I had been in my last job, last Trust for eighteen years. So it was a massive step coming into this role, at this level, in an organisation where basically I just didn't have a clue, you know, and it was very, very difficult in that coming from a comfort zone where I knew everybody, in fact I was like back there at my old hospital last week with my daughter as an outpatient appointment, and everybody was going, hello [name], hello [name], you know, which was really quite nice, I must admit. But I knew everybody there and I came here and didn't know a soul, so it was a big, big step.

LM: And what about the different, I mean just as a comparative, the different cultures of, of the place you'd worked and here…

MM06: Mm, very different.

LM: …was it significant?

MM06: Very different, it was a smallish hospital, it, it was [name] actually. I don't know if you're familiar with it at all?

LM: Yeah.

MM06: About three hundred beds. .. But very much .. different culture in that the people are very different, you know, it's predominantly sort of rural around there and, and people's outlooks are just very different, I have to say, from like inner cities. .. So the people are very different who you're dealing with and also your colleagues. At [name], the majority of staff lived on the doorstep whereas you come here and the staff travel from far and wide. So that was very different, you know, so very, very different, very different. I had worked here before at [site x] some time, I think it was before I had the kids, oh no in between, in between me two children I worked on ITU here, but that was only for a year. So I'd had a little taste of it, but.

LM: How do you find the split site, the fact that you are working across three sites?

MM06: Yeah, it's time consuming, very time consuming. You know, like for instance, this nurse who rang us up today to go down to [site w], you know, it's only ten minutes to [site w], if that, but it's getting from here to the car park, out the car park, down, you know, sort of like you have to allow really twenty minutes either side travelling time. Going to the [site y] is much the same. I get the bus across, I don't know if you're familiar with the bus service? I get the bus across but again it, you know, cos if you miss a bus then you're standing around waiting another fifteen minutes when you could be doing some work, it's, it's frustrating I have to say at times, it is.

LM: And do the different sites, are they, you know, do they all work the same or, or…?

MM06: Mm, mostly, mostly. There are some little differences but mostly they do. Apart from [site w], of course, which doesn't have the services that the, the larger sites, like they don't have laboratories and anything down there, so all their specimens have to be taxied up to here. They haven't got a bus service, so if I want anything from [site w] it has to go down in a taxi or vice-versa, has to come back in a taxi. .. But the [site y] and [site x] are much of a muchness really. But [site w] you can almost say is like a sleepy hollow, it's lovely though, it's lovely. (laughter)

LM: I have, I've been there once.

MM06: Oh it's fabulous.

LM: It's great.

MM06: Yeah, it's lovely.

LM: It's really calm.

MM06: It is, it is, and you can drive in there, when like today I've had a stressful morning and I drive down there and as soon as you hit that greenery you just think oh this is much better, you know, so (laughs). There's not the hustle and bustle down there that there is up here, so I quite like it if I go down there really cos I have a bit of chill time.

LM: (Laughs) And in terms of, just going back to, to what you enjoy most about your role, I mean you've already mentioned the staffing kind of issues and is, is there anything else particularly that grabs you about the role, or any challenges that you face?

MM06: I've had, well most of the challenges, I have to say, have been staff related. I have, you know, I've got a couple of wards where there's .. problems, for want of a way, a better way to put it, and it's been about getting in there and getting things done and, and turning things around. I've had huge leadership problems on 15 here at the [site x]. From the day I started it was absolutely desperate and the sickness was really high and, and so that's been a huge challenge and I've actually managed to turn that round now and I've got a really strong leader in post and the sickness is going down and, you know, and, and the care's gone up, and so that's been a huge challenge I have to say. I don't think I'm out of the woods yet, but .. that's my biggest challenge. I've got another one now just coming off at [site w]. So it's, it's about like almost putting things right, you know, a bit like a Ghostbuster going in there and sorting it out and, and I mean staff management is absolutely my forte, I'm very much a people person. I cannot get away with all this e-mailing business, you know, I, I believe in face-to-face contact. I want people to know who I am, I want them to be able to come and see us, and therefore if there's something wrong I go down and sort it out, I don't just ring up, and I think you

get a lot more back for that and a lot more respect, and basically people will do anything for you, because if you do for them, what you give to them, my firm belief is, you get back ten-fold. And like, for instance, the porter down at [site w] asked us to look at a complementary therapist for him, I don't manage the porters but I did it, and now he will do absolutely anything for me, you know, I went down, I was teaching down there on Tuesday and, you know, I had armfuls of stuff and equipment, and come on I'll help you, and, you know, and he's helping us, and I just think well yeah, OK, I did a little favour for you and now he'll do anything for me, and I think that really works. I don't think people really want a letter or an e-mail or a phone call, they want someone a bit person-to-person really, so.

LM: Absolutely.

MM06: But, I have to say, in some ways I think I'm the victim of me own success because now people find us approachable and know that I'll help them and they'll know that I've sorted out so they're never away from my door (laughter) and I have to be careful that I don't take on things that really some of the sisters should be sorting out themselves. So that's where I'm at at the minute really. Yes I've been very keen and, and very approachable in me first year but I, I'm starting to think now well hold on, hey I'm not going to sort this out for you and I think you can do that, and yes I'll support you but, you know, as a G grade I think you should be doing that. So I'm very conscious of that now at the moment, cos otherwise I'll just get burnt out cos (…) departments (…) so.

LM: I mean as you've been talking there's a couple of things. One is the…

MM06: Oh I can talk (laughter).

LM: No, that's good. One is the impact that staffing issues have on quality standards, which I suppose is, is, we'll probably come on to talk around Essence of Care in a moment, and the other…

MM06: Has gone (laughter).

LM: …is the perception that other staff, non, non-matrons have of the matron role…

MM06: Right, right.

LM: …whether you've got any comments on that?

MM06: Um .. I suppose they never know what I do really, but I think that's normal isn't it? People never really understand what I do. Certainly I would say from the F grades, which is the junior sisters and the, and the ward sisters, the feedback I've had has been very, very positive. They've all found us very helpful and very supportive and, and they'll sort things out basically, and that's what I want to hear, you know, I want them to be able to say that. So I've had some excellent feedback from the G grades who've

found us very helpful and very supportive, and the F grades. There's been quite a few E grades who I've had dealings with who are also, you know, who think yeah, good, yeah, she'll help us, she'll sort us out, and I think, for the main, the role is seen as supporting predominantly the ward sisters who actually have a really tough job and I think they need, they need support, and very often, you know, if I wasn't around they wouldn't particularly have anybody to turn to, and it's a tough role being a ward manager and I think they need somebody. So a lot of the time I'm just a sounding board for a bit of whinging or a bit of moaning about somebody who's gone off sick again.

LM: (Laughs) Looking to the, I suppose the Department of Health ten key objectives for the modern matron role, how does that fit in with what you do?

MM06: Well you'll have to remind us of what the ten (…) are. Audits, what, cleanliness is big on the agenda isn't it?

LM: Yeah, it's the cleanliness, it's the, all of those sorts of things.

MM06: Yeah, we do cleanliness .. reviews. I'm supposed to do them every month and I don't often get them done every month, and we have a pre-set form and go round and check everything. So we try to link into that. .. It's infection control and cleanliness really isn't it? I mean…

LM: MRSA and…

MM06: …and, and visibility, you see, is one of the other key objectives which I'm always conscious that because I have so much sort of what I would class as being paperwork to do, you know, the public want you to be there, they want matrons to be visible and I don't feel sometimes I'm meeting that, because I'm so bogged down with other things as well, because I think everything involves clinical governance and, you know, there's lots of things, so probably don't meet that. But there'll be other matrons who you'll speak to in other areas who've got a much smaller patch who actually work on the wards and are visible. So, you know, I envy them in some ways, you know. (laughter)

LM: It does seem to depend very much on the context…

MM06: On your patch.

LM: Yeah and the patch.

MM06: Yeah.

LM: Yeah.

MM06: Yeah.

LM: Who would you regard to be your peers within this organisation?

MM06: Um .. [name] is the matron for Medicine, so me and her work very closely together, I have to say. So it's mostly the other matrons I have to say. .. I rely heavily on, I relied heavily on [name], I have to say, when I first started and found her very supportive, very supportive. But it's very difficult when you want just a bit whinge and a bit moan, as we all do in life don't we? (laughs)

LM: Mm hmm.

MM06: Being at this level and being isolated really, because, you know, I'm here on me own at [site x], [name] at the [site y], [name] at the [site y], so it's sometimes difficult, that's another thing what, you know, when you're at this level, there's not very many people you can just whinge or moan to. If you're just having a bit of an off day, you know, and it's nothing in particular and you just want a bit whinge (laughs) I whinge to the wall (laughter).

LM: Yeah, ah. So how, how do you, as a group of modern matrons how, how does that work, how do you communicate with one another and, and how do you (…)? (talking together)

MM06: We have a matrons' forum which is probably every month I think .. but that's probably the only real sort of .. meeting we ever get together as, as a group really. .. I would imagine that's it really, and some of the matrons I have very little contact with, very little, I don't really know some of them, you know, and, but then again I think there's about twenty of us, so, and we're spread out. Again it's, you know, it's the large Trust really isn't it that, there's not the close-knit. But .. like I say, I've got [name] obviously who's under the same directorate as myself and, I mean the, the Orthopaedic matron upstairs, I sometimes whine to her, you know, we have a bit whinge, get your tape recorder (…) (laughs). But no we, I suppose we don't meet very often.

LM: So what happens at those forums, what are the sorts of things that you would…?

MM06: A lot of it's sort of any new developments coming along, we look at where we're going with key objectives, we look at, we also have, also we have an Essence of Care steering group as well, so there's matrons at that, yes there's the two. .. We've recently been all involved in uniform audit where we've been patrolling the exits and entrances to all of the sites catching nurses travelling in their uniform.

LM: That was on the agenda in May.

MM06: Was it? (laughs)

LM: Yes, that was discussed in the meeting.

MM06: It was fantastic (laughs). The excuses you got, whey, crikey, apart from I had to be here at six o'clock in the morning. But, you know, it was really, it was an eye opener really .. and we look at the cleanliness things, because as well as doing our own areas we

have, until just recently, it's only just been stopped last month, we then also had a rota where me and somebody from another directorate would go to a totally different area and inspect that area as well.

LM: Oh right, OK.

MM06: So it's a bit like outside eyes coming in, so.

LM: And that was at matron level?

MM06: Mm hmm.

LM: Yeah, yeah.

MM06: So yes I suppose the key, you see it's coming back to us now, I link with other matrons in that respect, cos I would have my name against somebody else's name and I would meet up with them and we'd go, choose which areas we're going to go to and that. So I linked up with them there.

LM: And, and what about the, the Essence of Care steering group, have you had much to do with that or…?

MM06: I've been at a few meetings yes when we particularly look at Essence of Care, where we're at, where we're going, what we're doing and just reflect on what we've done and, and where we are and how we're moving on and, a couple of people might have been away to a conference and they feed back on that, so. But I haven't managed to get to an awful lot, I have been to some but not an awful lot.

LM: So tell me about Essence of Care? (laughs)

MM06: Well it was entirely new to me when I came, the format, obviously I was aware of Essence of Care, but it was very low key where I'd come from, and I mean it's quite a, a, a well established thing in this Trust I have to say, the, the wards were quite used to it. I mean personally I didn't have any training (laughs) with coming in after it had started, it was more or less just thrust under me nose and said, here, this is what you do, you get on with it and that's that, you know. And so it was a bit difficult for me not, I didn't quite understand it and wasn't sure how it worked, and being new in post it was very difficult, this was just something else, you know, all caving in on top of us, and it took us a good while to really get to grips with it. But I met with [name], the Essence of Care support nurse, and she went through things with us and said "Look, this is what you should be doing, this is what you need to do" and dah-de-dah-de-dah. .. So I felt much better after that, I felt like I knew upstairs in me head what was going on and what was expected of me as well .. so I felt happier that I knew where I was going with that.

LM: So is that about the process…

MM06: That's the process.

LM: …that this Trust has…

MM06: Yes.

LM: …has taken on?

MM06: Yeah, yeah.

LM: Yeah.

MM06: Yeah, I didn't quite understand the processes I suppose, yeah.

LM: So how does that work then, I mean that, the, the whole audit process?

MM06: Right, yeah, well we get it from, well I believe, before I came into post, that the matrons all got together and split up into little groups and devised a benchmark each, the document, and then .. when that was ready we had a programme of when we were bringing them out and we, it would come to me, I would send it out to all of my wards and departments, give them a day that it had to be completed by, get them all back in, look through them all, now I'm missing out me compare and share aren't I? You see, that's because I didn't know about me compare and share at first. (laughter) Well get them all back in and then, at first, what I was doing is I was looking through them all and then from that compiling my report, which I then sent off to [name], and then [name] sends them to whoever devised that particular benchmark and they coordinate the whole responses from all the directorates and bring out a final report. But what I've found, since I spoke to [name] and realised that I should be having these compare and share meetings that I didn't really know about, what I've found now is that I ask the wards to bring their compare and share, to bring their tool to the compare and share meeting and then we sit and discuss it and the pros and cons of each benchmark, what was difficult, what was easy, what was good, what was bad, and I tend to write me report from that now, from the meeting. Because the, the good practice comes out and the learning points come out in the meeting, and so I tend to write it from that. I do, I do look through the documents, but in general I get most of it from the meeting, I have to say.

LM: And how extensively is, is this rolled out then, is Essence of Care audit rolled out, I mean is it every single (…)? (talking together)

MM06: I send it to all of my wards and departments, yes, and there's some of it that isn't .. applicable to like the Falls and Syncope Service, say the personal care one which was basically about washing and dressing patients and hygiene needs, but they're an outpatient service so they don't have anything to do with washing and dressing patients. So, you know, that wasn't applicable. But I still send it out to them because I think well, you know, they can look at it and just see what the rest of the, the directorate's having to

do and, you know, there might be the odd bit that they can pick up on, say like for instance, the toilets, you know, do you have separate toilets for males and females, and even in an outpatient department then you do. So I do send it out to all of them. I mean they've got the day hospital as well so a lot of it wasn't applicable to them. .. And like the continence one, well, you know, outpatient services don't have an awful lot to do with that, so, but I still send it out to everybody.

LM: And, and what's your view on how, how, you know, frontline staff have responded to it?

MM06: A bit mixed I think. I think my feeling is that it's good, it makes the ward sort of sit up and think about their practice, it lets them look at what's maybe not good and what is good. .. But, on the other hand, I think they find it very, very time consuming, it's quite a lengthy thing to go through. .. Some wards are much more thorough than others, so, and it depends who does it as well, it depends which member of staff does it. Some are sending very sort of abbreviated snippets of information, others go in great reams and reams and reams. .. So I think it's a bit mixed. I think, you know, it is time consuming .. and I think there's always the doubt, is it really changing practice, and certainly I, I, you know, if I was to be extremely truthful with you then I would have to say that as well. You know, I'm, I'm not convinced that it's actually changing practice. I think it's changing some, but I'm not sure that the amount of time it takes to actually do this whole tool. If I put it this way, those ones I thought well I'd be better off going round the wards, showing them what I use with the incontinence pads than having to read, write all of this down and write reams and reams and reams. So, you know, just as an example like that.

LM: Yeah, I mean one of the questions I've got is, what kind of things have been achieved to date through the approach that the Trust has taken with Essence of Care.

MM06: I think there's been, I mean we've only got three final reports out I think, but you see that's, I think, perhaps been a bit of a downfall in that they've done these tools, they've come to me, I've done my report, I've sent them off, but then the time between the ward completing the audit and the actual final report coming out has been months and months and months, in which time they've had several other tools to do, so they've forgotten what they identified as being their action plan in that first tool. So the time delay I think has, has been significant in a negative way really, because they've forgotten all about that one, because they've had several more in that space. And then it's about trying to reflect on, on the earlier ones and saying, you know, are you doing this, and what I started doing in my last few compare and share meetings was asking them to bring along their action plan for some of the earlier ones and just going through it briefly and saying, right, have you done this, have you done that and have you done such and such, and trying to pick up on it that way and close the loop.

LM: And, and, but what were the kind of results from that then?

MM06: Not bad, I have to say, not bad. I mean off the top of me head I can remember that the nutrition one, you know, the MUS tool, which was the assessment tool, you know, that was being widely used now and it was being used throughout all the wards, whereas prior to it hadn't been. So, you know, there was cutlery available on all the wards, you know, specially adapted cutlery and stuff like that, that was available on all of the wards, and napkins were given out, Wet Ones were given out prior to meals for patients to wipe their hands. So yes, you know, it had been achieved actually, it, you know, so .. and I may be being a bit cynical. But, you know, I can see there has been good come out of it, definitely. It's lovely that patients get a Wet One to wipe their hands before a meal, you know.

LM: I suppose the question then is .. are these outcomes, would these outcomes have happened anyway?

MM06: Yeah.

LM: Or is it to do with Essence of Care?

MM06: Yeah, and I think you have to say it's to do with Essence of Care. What you can take on from that is, does it need such a huge lengthy process just to give somebody a, a Wet One to wipe their hands with before their lunch, you know, that to me would be the question. But then what other way could you do it, so, and I don't know the answer to that either. So there is good come out of it, and for me one of the, my favourite things that has come out of it is about privacy and dignity. Cos now all the wards, certainly in Elderly Care and my lot, have got little signs that say 'personal care in progress' and they have a clothes peg what you peg your clothes on the line, one of those pegging the curtains together, because one of my great things is people just go barging behind curtains, where's the keys, have you got the keys, you know, and the patient can be in an undignified position or whatever .. and, you know, closed curtains means stay out, and to me putting these little pegs on, well people have then got to unclip the pegs, so they don't do it, so they don't go in. So that's my favourite, I have to say, outcome of it.

LM: And I suppose the question there is the scale of the change that's occurring, you know, I mean that's a very…

MM06: Yeah.

LM: …simple…

MM06: Very simple, quite small really, but I suppose you could argue a huge impact, cos much better to have curtains closed and nobody barging in behind them, and, you know, again it wasn't something I had ever thought of. It irritated the living daylights out of me for the past twenty-eight years people coming behind curtains when, you know, you're busy with a patient, but I never thought about putting a clip on. So getting together and people saying, oh well we've got little clips and we put them on the

curtains, and I thought hey what a, you know, it's not rocket science is it, it's excellent. So, so, you know, so yes there is good come out of it.

LM: And is that, when you say people are pooling their ideas, is that through the compare and share?

MM06: I've found, yes because what I did was, particularly with that one, when it was a ward here that was using them, I dragged everybody else along (laughs) to have a look so they could see it first hand, you know, just what we meant. Because, with the best will in the world, you can give ideas to people and they just formulate in their own head what you're talking about. But, you know, I took them along to the ward and, cos we were only along another ward having a meeting, so we all just marched along and had a look at their little pegs and their little notices and, oh right, what a good idea we can do these on the computer and we can go to Woolworth's and buy some pegs and, you know, so it was dead simple. So they are using them, so I'm pleased about that.

LM: When, when people come to the compare and share, what kind of mix of, of staff have you got within those groups?

MM06: I usually ask for the person who's completed the audit to come along, because then they know the pitfalls, they know what was wrong, and sometimes the scorings are a bit bizarre on them and sometimes they seem to lose points when it's actually been a positive thing. So we always thrash that out. So it's predominantly staff nurses, but I have had a couple of sisters who've done the audits, they've come along as well, so. But it is predominantly a staff nurse who seems to do it.

LM: And in terms of the wider, I suppose when actioning the action plans would you have a wider group of people, health care assistants, dieticians, etc, etc?

MM06: Well I, when we're talking about the action plans that have already, that are already in place I tend to just use the same group and they take it back and sort of like fire them up and say, you know, go back and make sure this has been done and, and give them some ownership really and some responsibility, so. But then, you see, again the next question is, you know, are they doing that and how are we going to follow that up, and, and I think, you know, there's plans to sort of start rolling them all out again come October. So we'll start then to pick up on is this really still going on and see how we've scored and .. things like that, so.

LM: And the sense I'm getting is that there's a very clear structured process…

MM06: Very structured, yeah, very structured.

LM: …which, you know, which has its, its clear benefits, but then it's the under, you know, it's the what happens next question.

MM06: It is, yeah, and it's getting into that what happens next isn't it? And, you know, yes we've identified this, yes we're going to do that and yes we've learnt this from it, but are we really going to do what we say we're going to do in the action plan? And that's the bit that concerns me, I have to say, and getting in there to, to look at all of that is, will just be like, you know, very, very time consuming.

LM: Just when I asked you to start telling me about Essence of Care and you said it was very different in the other places…

MM06: Mm.

LM: …much more low key…

MM06: Didn't do anything (laughs).

LM: Right.

MM06: Nothing.

LM: Right, OK. Cos my question was going to be how, how…?

MM06: There was no process like we have here, at all, not at all. Essence of Care was something that was bandied about and .. I think in some of the community hospitals they had done some sort of talks and series of like structured sort of programmes around some of the benchmarks, predominantly in childcare assistants I believe, I wasn't involved in that though. .. But certainly where I was it wasn't, there was no structured process whatsoever, it was just a term, like clinical governance or whatever, and people were aware of it and that was that.

LM: Do you .. do you feel Essence of Care has, has a place and has a, has a, a value?

MM06: I do, uh huh, absolutely, because it's basic care at the end of the day, it's not, you know, anything. .. In fact, to be honest, it's sad that we've had to come to an Essence of Care programme when really, at the end of the day, it should be what nurses are being taught in their first year of training. So that is quite sad, it's quite worrying to think that, you know, nurses aren't learning this any more and we're now having to have this whole programme and, and I think, you know, that, that is a bit worrying really isn't it?

LM: Mm hmm.

MM06: That we've got to this because nurses basically have forgotten about privacy and dignity and washing people and, you know, attending to their continence needs and stuff and, so it's sad. But I think that's all about the training as well isn't it? nurse training now is so different to when I trained that .. you know, they don't look at that because they think it's, they're going to learn all of this in your placements, whereas in my day,

you know, like the days of Florence Nightingale (laughs) you, we learnt it all in school, so. So I suppose it's just progress isn't it?

LM: Mm hmm.

MM06: So. (interruption – recording paused)

LM: Going back to putting, you know, actually implementing the Essence of Care, where it's come back to the directorate you've kind of…?

MM06: The completed ones?

LM: Yeah, the, the audit and everything, what have been the things that have really helped it along and what are the things that have caused barriers or limitations to how much can be achieved?

MM06: Helped, what (…)?

LM: Helped the .. action planning and, and helped make, putting those improvements in place on the back of having done the audit?

MM06: (Pause) Do you mean from the ward's point of view?

LM: Yeah, yeah.

MM06: What's helped them?

LM: Yeah.

MM06: I suppose when they look at, because it's so structured I think, and know what they hadn't scored well on, they know what they have scored well on, so then they have to look at what they've scored badly on and think right, we've got to do something about this. So I think the scoring system helps because that identifies where their weaknesses are and what they have to do about it. There's been some things where they haven't got a clue about some of the things on the thing, on the audit tool, I forget what the one was in the last one, but nobody had known anything about it (laughs). So .. everybody came back saying, must find out about whatever it was now, I can't even remember, it was something like a Red Cross leaflet or something, I hadn't heard about it. .. So I think that's helped them to do their action plans, definitely. .. As for hindered the action plans .. oh I'm not sure really. I think .. sometimes I wondered about communication. Like one example was .. it was called Patient Line, you know the Patient Line where all the patients have a television now at their bedside?

LM: Yeah.

MM06: [site w] hadn't even heard of that, so all of theirs was coming back saying, what's Patient Line, because they don't have it down there, what's Patient Line, must

find out about Patient Line. So then you start thinking well crikey, they don't know what's going on in the rest of the place, so. I think some of the .. some of it was duplicated as well, so that they were thinking well we had this in the last action plan, do we put it in this action plan, because there is quite a lot of duplication in the tools, especially when you come like, to things like documentation and involving patient and carers. .. So I think there's a bit of difficulty there, cos you think well we've already done this, do we have to do it again, don't know, some put it in again some don't, so. And some, some don't complete them right. (laughs) Despite the fact that they've been doing it for a year now, some of them still don't, they miss off the last three pages which is, to me is the most valuable piece which is the learning points, the best practice and the action plan, they miss that off so I have to send it back, so.

LM: How has it been communicated across, I mean you said when you came in, you know, you didn't really know what it was and it was only when you sat down with [name]…

MM06: [name], yeah, yeah.

LM: …you, you started to get a feel. Has, has that kind of level of awareness raising and training gone on across all staff then or…?

MM06: I think the matrons who were in post had a lot of sort of workshops on, on the whole programme, which was before I came into post obviously .. I believe anyway, and they had quite a lot of training and I sort of like just had to slot in and pick it up as I was running along. .. But [name] has awareness days now and has, cos I actually was lecturing on one of them not so long ago, so, and they're well attended, I have to say, so she has them as well.

LM: I think I need to talk to [name].

MM06: You do, yes, she's only…

LM: (Laughs) Her name keeps popping up.

MM06: …part time, I think, a couple of days a week, [name].

LM: Oh well I'll, I'll speak to her. Given, you know, if you just look back on your time here and since getting involved with Essence of Care, the audit, etc, what, for you, have been the key critical things that have enabled it to work here?

MM06: Cooperation of the staff probably. The staff are quite keen I think. The staff want to do better, they want to improve their practice and .. I have had excellent cooperation. You've sometimes got to badger them to get them in, you know, they're sometimes a bit slow. But .. I do think they have co-operated quite well, and I can only assume that it was sort of widely publicised before we started the whole thing and, I don't know, there must have been awareness days or whatever to all of the staff, because

everybody was quite keen to take it on board and, and, and do it. So I think probably co-operation has to be the main thing that's helped it to work really, and people want, I think generally nurses want to improve their practice and they see it as a good way of sort of finding things out and, and see what they're doing right and what they're not.

LM: Is it significant that it's nurses rather than other (…)? (talking together)

MM06: I think it is, and I think there's a, certainly in our directorate there's a, a feel that the medical staff should get more involved and .. perhaps the OTs and the Physios. My personal feeling is that a lot of the benchmarks are very nursing orientated and therefore I think it is appropriate that the nurses should do them. Documentation yes, you know, you could argue, and record keeping you could argue that yes everybody should be involved with that, and they should, but I still think it, it has to be a nursey thing. I think the whole, the whole feel of, of Essence of Care is, is nursing orientated and I, I think it's appropriate that it's nurses. I think the medical and the other professions should be aware of it, and we're trying to do that though our clinical governance meetings now, but I still think it has to stay with the nurses.

LM: Just, is, is there a link between clinical governance and Essence of Care?

MM06: Yeah, yeah, yeah.

LM: And, and how, how is that?

MM06: Because clinical governance is about improving standards and, and, you know, doing all sorts of risk assessments and looking at quality of care and things like that. So Essence of Care slots very nicely into clinical governance. So we have these clinical governance meetings every two months now and we have an Essence of Care slot, sort of just what's going on in the directorate, what's up-to-date, what's not.

LM: And that's a multi-professional?

MM06: That's multi-disciplinary.

LM: Multi-disciplinary team?

MM06: Yeah.

LM: Yeah, that makes sense, yeah.

MM06: So that's a way of letting them know what's going on.

LM: And do you get a sense at all of .. I don't know how to ask this cos it's off the top of my head (laughter) so I have to think about how I phrase it. .. A phrase that's been used is that this is a must do, Essence of Care is a must do…

MM06: Mm, mm hmm.

LM: …is that something you think, when, when you're talking about staff cooperating do you think they're cooperating because…?

MM06: Because they have to?

LM: Yeah.

MM06: Hmm, mm hmm, mm hmm. .. I think there will be some who yes are doing it because they have to and see it as tedious and laborious, but I think there's others who are quite keen to do it. Probably split, certainly across my wards, yeah, yeah. Some who, yeah .. dare I say it, the older school (laughs) nurses probably think it's just another paper exercise, the younger nurses have probably been trained much more in this way. I mean I wasn't trained in this sort of way with all of this paperwork and benchmarking and audit and all the rest of it, so they're much more familiar with this way of working and, and they're much keener, I suppose, and eager and, and used to, to dotting t's and crossing their i's and all the rest of it, whereas the old school ones probably think well, you know, just get them in school and teach them how to do it and we wouldn't need this, so that, probably half and half.

LM: I suppose just taking a, a step out of Essence of Care generally, but, and, and thinking about benchmarking as a whole, is that something that's relatively new to you or…?

MM06: It's fairly new, it's been around a while, six/seven years. I think it sort of was another term that came out along with .. clinical governance and that sort of era, and there was all these terms being bandied about and people were saying, what's benchmarking (laughs). .. So it's been out a good while I think. It's, it's probably not a term nurses were very familiar with for quite some time, and certainly I can remember when it was first being banded about, thinking what on earth's benchmarking, and finding it very difficult to find anything about it, so. But it's been around a while, but.

LM: And perhaps, as time goes on, familiarity?

MM06: That's right, yeah, and then we'll have another term comes out before long and we'll all be thinking, what's that, you know.

LM: Well somebody did say to me "What are you going to do for your PhD if Essence of Care gets moved and shifted off the agenda?" (laughter) at which point I thought good question, I'd not thought about that.

MM06: It's called service development and progress (laughter).

LM: Yeah. .. I'm aware of, of the time and, and what have you. But .. we've kind of gone round all the different topic areas here, I just wondered is there anything that I haven't covered or asked you that you feel is important to say at this point about Essence of Care within this Trust?

MM06: No. .. I, I suppose the only thing is I'm still having a view that this should be done in nurse training, you know, I do think that all of this should be incorporated in nurse training and, and then, you know, nurses would know it (laughs). But that's trying to take on the whole nurse training aspect isn't it I think? That, that's certainly one of my views. But, having said that, the matrons have actually now been invited into the universities to do clinical based teaching, and I think that's definitely a move forward, and I think again that's linked into Essence of Care. Because they want the matrons to go into school to teach the nurses how to bed-bath and, you know, care for people's mouth and whatever .. albeit in the classroom setting, but in some ways I wonder if that's like a step back, because that's the way I was taught to bed-bath somebody, I was taught to bed-bath in school by a tutor, a nurse tutor, you know. So I think maybe that's a good move. I haven't actually done any yet, but I've put me name down to do it .. because again I think it's, it is Essence of Care and it's, it's just taking it into the classroom, which I some, although you could argue it's on the ward, I sometimes think the basics have to be taught sometimes in a, in a classroom setting (is my kind of thing really?). Cos I always think if you get a mentor who has never been taught how to bed-bath properly then as a student nurse you're not going to learn to bed-bath properly, and I think that's why standards perhaps have slipped, because in my day, you know, donkey's years ago, it was the nurse tutor who taught us, very rigid, this is what you do and this is how you do it.

LM: And do you see that being at all the matron role now?

MM06: I would like it to be, yes, yeah, yeah. Again I would like, as a matron, to be able to take all the student nurses and say "Right, come on, show me how to do this." Spend time with the student nurses, cos they're our nurses of the future, and just, you know, but because of so many other things in the job there just isn't the time to do that.

LM: One final question is who, in your opinion, are the key players within this Trust around Essence of Care?

MM06: Oh definitely [name], she's an evangelist for it, yeah. I think she's, she's definitely at the helm and she drives us all forward with it and, you know, keeps the enthusiasm up that keeps us motivated with it and .. she's very positive about it. So I think she's definitely the driver.

LM: And are there anyone, any others aside from [name] that you think are…?

MM06: I think there's a couple of the other matrons who are very, very .. very into it and think, you know, there is a couple of the other matrons who seem to take on quite a, a lead role. I mean [MM03] is one of them, he's quite, he's setting up the Essence of Care website, wow (laughter). You know, so he's, he's .. quite into it as well.

LM: Yeah. There, there's a sense that the, the matrons, as a collective, are taking a lead role…

MM06: Yeah, definitely.

LM: …but within that you’re going to have key people who are…

MM06: Yeah, yeah.

LM: …pushing certain aspects of it.

MM06: Forward, yeah.

LM: OK, great.

MM06: Was that helpful?

LM: That’s really helpful. And unless you’ve anything else to add at this point?

MM06: I don’t think so, I don’t think so.

LM: You can always e-mail me.

MM06: Sure. (laughter)

LM: Or call me. I’ll, I’ll turn this off.

(End of Interview)

Appendix J: Initial Coding: descriptive hierarchy

1. **Personal Motivation**
    - 1.1. Matron Role
    - 1.2. Nursing profession
    - 1.3. Clinical Involvement
    - 1.4. Management
    - 1.5. Personal Achievement
    - 1.6. Learning
    - 1.7. Responsibilities
        - 1.7.1. Patients
        - 1.7.2. Colleagues
        - 1.7.3. Policy
    - 1.8. Reflection on professional practice
    - 1.9. Career Path
    - 1.10. Experience

2. **Organisation & working with others**
    - 2.1. Reporting Lines
    - 2.2. Managing
    - 2.3. Communicating
    - 2.4. Process and Procedure
    - 2.5. Culture
    - 2.6. Structure
    - 2.7. Difficulties/Challenges
    - 2.8. Senior Management

3. **Essence of Care (EofC)**
    - 3.1. Organisational approach/ structure / process
        - 3.1.1. EofC Steering Group
        - 3.1.2. MM Forum
    - 3.2. Matron responsibilities
    - 3.3. Knowledge of benchmarking / EofC
    - 3.4. Value of EofC
    - 3.5. Feelings towards EofC
    - 3.6. Change as a result of EofC
        - 3.6.1. Personally
        - 3.6.2. Organisationally
        - 3.6.3. Attributable to EofC
    - 3.7. Success/Benefits
    - 3.8. Challenges
    - 3.9. Failure Involving other staff (Multi-Disciplinary)
    - 3.10. Adaptation/Interpretation of EofC
    - 3.11. Links to other organisational activities/policies
    - 3.12. Critical Factors

4. **Feelings**
    - 4.1. Enjoyment
    - 4.2. Frustration
    - 4.3. Satisfaction
    - 4.4. Motivation

5. **Working with others**
    - 5.1. Credibility with colleagues
    - 5.2. Loyalty & Trust
    - 5.3. Acceptance by others
    - 5.4. Insider/Outsider (Matron role)
    - 5.5. Peer Support
    - 5.6. Them/Us

6. **Government Policy**
    - 6.1. In practice
    - 6.2. In theory

7. **Organisational Improvement**
    - 7.1. Experience of
    - 7.2. Initiatives
    - 7.3. Views/Opinions on
    - 7.4. Outcomes of

8. **Modern Matrons (MM)**
    - 8.1. Working together
    - 8.2. Collective action
    - 8.3. Collective behaviour
    - 8.4. Challenges

Appendix K: Data Extract - example of Initial Coding

lot of, of clinical input really. A lot of, you know, Ward 2 were short-staffed this morning due to a problem, so I've worked on there this morning before I've come here to see you. So, you know, and it's very easy to be able to slip into each of those roles.

LM: Is the modern matron role relatively new within this organisation?

MM01: Um .. it's, I've been in post two years and there's probably .. I think the first matrons were probably, well not appointed as matrons, I think they were in existing roles that were changed, that were rebadged roles really. So I was probably one of the first, so I don't think me first, but one of the first appointed matrons. .. So prior to that there were probably matrons in post for about eighteen months/two years, but they were all rebadged roles, so people who'd been assistant speciality managers or had some kind of managerial type title. Then suddenly the Government said we needed to have matrons, so the way we, as an organisation, approached it was if people who were in positions where they thought that would be an ideal matron type role, just one minute you came to work and the next minute you were a matron, you know, just sort of rebadged roles. But, you know, that, that's only a proportion of the matrons that are in post now are matrons who were in rebadged roles. There's probably about, I don't know, maybe there's about, I would say there's probably about eight of us now, maybe a little bit more than that, probably about eight who've been appointed to the role of matron, not people who've been in rebadged roles.

LM: OK. And generally how have people reacted to the matron role, you know, other, other staff, other colleagues?

MM01: I mean I can only, I can only say from my experience that people have acc, people have accepted it very well. I think, I think from my experience, I'd worked in the department for a lot of years so was very sort of well known within the department .. I think some people perhaps had

some, I don't know, some confusions about what your role was and what you were there to do and what your responsibilities were. But I think that's probably, you know, I think that's probably true of the matron's role. I think it's very, it's got very broad guidelines in terms of what your areas of responsibility are, and because it's a role whereby you can .. you can implement it in different ways, you know, I think that, you know, we would say that across this organisation we all do our jobs very differently. .. So I think that, you know, if we're doing it differently then how can other people ex, you know, I think, expect to know exactly what the responsibilities are. I think there is a big tendency for it to be a role where you get everybody's problems, you know, I think that perhaps a little bit about the things that other people either can't or .. can't sort out or won't sort out, then you get a lot of, you know, you do get a lot of problems sort of dumped on your doorstep type of thing. But I do think that, that is an element of the role, cos if you're, if you're looking at clinical standards and maintaining high standards of clinical care, which I think is, you know, I think that has to be the emphasis of everything that we do, then if there's problems in making that happen then you need to respond to that. I think it's a very difficult role in terms of the idea of, the role is that you supposedly empower others to do their job more effectively and I think that's probably one of the things that's more difficult to do within the role.

LM: And why would that be, do you think?

MM01: Because I think, I mean I don't know, well I think it's because I'm aware that there are many pressures within the system. I think that people, you know, as, as any Trust, we're working under immense financial pressures .. and I think that those pressures translate in terms of available staff and resources. So if somebody's coming to you and saying, look I've got a problem, what do I do about this, then sometimes the problems that they're coming to you about are that, you know, I'm just too busy, the sky's about to fall in type of thing and I need somebody to help me with this, and sometimes it's very difficult to turn that round into a

situation and say, well look, you know, how would you deal with it, you, what do you want to do about it, you know. Cos, you know, the place is falling down around people's ears in terms of everything being busy, and if they're coming to you and saying, look can you help me with this, often they just want you to help and it's very difficult to then turn round and say, well I could do that for you, but I think it would be better for you if you sorted it out, you know. Cos that's not what they're coming, you know, I don't think people come to you for, I think they, they come to you for help because they're used to you being there now and I think that, I think there are probably things that they could sort out for themselves. But .. equally I think there's an issue when the role, you know, when your, your role was developed and you were put into post, you were wanting to seen to be helpful to people, you know, you wanted to be seen as somebody who within, you know, putting this extra tier in was going to help people on, on the shop floor, and most people see that help as being .. somebody to do something for them, you know. So I think it, it is a very fine balance between, you know, helping people or just doing their job for them, and it, it's a difficult balance to strike sometimes I think. And it's probably more difficult, you know, there are lots of things about my job that are easier because I've been the ward sister on Ward 3 and there are lots of things that, that make that a lot easier .. but it also probably makes it more difficult because people, if you've, if you've come from outside of the area and people don't know you then I think they're probably less likely to say, can you just sort this out for me, can you just help me with this.

LM: Yeah, yeah. In terms, I mean one of my questions was going to be what are the challenges of the role, and you, you know, I think the empowering people…

MM01: Yeah.

LM: …and the huge agenda would appear to be…

Appendix L: Focused coding matrix

THEORETICAL CONCEPT: AUTHORITY

Level of Organisation			
	CORPORATE	DIRECTORATE	INDIVIDUAL
D1			
MM01			
MM02			
MM03			
MM04			
MM05			
MM06			
MM07			
MM08			
MM09			
MM10			
MM11			
MM12			
MM13			
MM14			
MM15			
MM16			

NB: The matrix would be populated with relevant quotations from individual Matrons, according to whether they were speaking with reference to the theoretical concept and on which organisational level.

Appendix M: Search Results "Syncretism"

Search Results for "syncretic*" AND "identit*"

	Search Terms	Management Databases				
		Business Source Premier	Emerald	JSTOR	British Humanities Index	ScienceDirect
Search Results	"syncretic action"	0	0	0	0	0
	"syncretic*" AND "identit*"	4	18	11	11	29
Relevance to management		1	6/18	0	0	0
Content		Sense-making & Roles	PR/Communication Inter-firm collaboration CSR Partnerships			

LIST OF ABBREVIATIONS

AfC	Agenda for Change
BMA	British Medical Association
DH	Department of Health
GMC	General Medical Council
LEO	Leading an Empowered Organisation
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NMC	Nursing and Midwifery Council
NPM	New Public Management
OD	Organisational Development
RCN	Royal College of Nursing
SIT	Social Identity Theory
UKCC	United Kingdom Central Council for Nursing, Midwifery & Health Visiting

REFERENCES

Adcroft, A. & Willis, R. (2005). The (un)intended outcome of public sector performance measurement. *International Journal of Public Sector Management,* Vol. 18 (5), 386 – 400.

Ainsworth, S. & Hardy, C. (2004) Discourse and Identities in Grant, D., Hardy, C., Oswick, C. & Putnam, L. (Eds.) *The Sage Handbook of Organisational Discourse*. London: Sage Publications, pp.153-174.

Ainsworth, S., Grant, D. and Iedema, R. (2009). 'Keeping things moving': space and the construction of middle management identity in a post-NPM organisation. *Discourse & Communication,* Vol. 3 (1), 5-25.

Allan, H.T. & Smith, P. (2005). The introduction of Modern Matrons and the relevance of emotional labour to understanding their roles: developing personal authority in clinical leadership. *International Journal of Work, Organisation and Emotion,* Vol. 1 (1), 20-34.

Alvesson, M. & Karreman, D. (2000). Varieties of Discourse: on the study of organisations through Discourse Analysis. *Human Relations*, Vol. 53 (9), 1125-1149.

Alvesson, M., Ashcraft, K.L. & Thomas, R (2008). Identity matters: reflections on the construction of identity scholarship in organisation studies. *Organisation,* Vol. 15 (1), 5-28.

Angrosino, M.V. & Mays de Perez, A. (2000). Rethinking observation: from method to context in Denzin, N. K., & Lincoln, Y. S. (Eds.) *Handbook of Qualitative Research* (Second edition). London: Sage Publications, pp. 673-702.

Ashforth, B.E. and Mael, F. (1989). Social Identity Theory and the Organisation. *Academy of Management Review,* Vol. 14 (1), 20-39.

Ashman, M., Read, S., Savage, J. & Scott, C. (2006). Outcomes of Modern Matron implementation: Trust nursing directors' perceptions and case study findings. *Clinical Effectiveness in Nursing,* Vol. 9 (S1), e44-e52.

Badham, J., Wall, D., Sinfield, M. & Lancaster, J. (2006). The Essence of Care in Clinical Governance. *Clinical Governance: An International Journal,* Vol. 11 (1), 22-29.

Banaji, M.R. and Prentice, D. A. (1994). The self in social contexts. *Annual Review of Psychology,* Vol. 45, 297-332.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of tail wagging the dog? *British Medical Journal,* Vol. 322 (7294), 1115-1117.

Bate, P. & Robert, G. (2002). Studying health care "quality" qualitatively: the dilemmas and tensions between different forms of evaluation research within the UK National Health Service. *Qualitative Health Research*, Vol. 12 (7), 966-981.

Baumeister, R.F. (1987). How the self became a problem: a psychological review of historical research. *Journal of Personality and Social Psychology*, Vol. 52 (1), 163-176.

BBC News (10-05-2004) Nurses cannot be too posh to wash. http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/3701855.stm [Date accessed: 3-Mar-2011].

BBC News (05-04-2011) NHS Changes: points of contention. http://www.bbc.co.uk/news/health-12971361 [Date accessed: 5-Apr-2011].

Berger, P.L. and Luckmann, T. (1991). *The Social Construction of Reality: a treatise in the sociology of knowledge.* New Edition. London: Penguin.

Berk, G. and Galvan, D. (2009). How people experience and change institutions: a field guide to creative syncretism. *Theory and Society*, Vol. 38 (6), 543-580.

Berman, P. (1978). The Study of Macro and Micro Implementation of Social Policy. *Public Policy,* Vol. 26 (2), 157-84.

Bolton, S. (2003). Multiple roles? Nurses as managers in the NHS. *The International Journal of Public Sector Management,* Vol.16 (2), 122-130.

Brannen, J. (2005). 'Mixing Methods: The Entry of Qualitative and Quantitative Approaches into the Research Process'. *International Journal of Social Research Methodology,* Vol. 8 (3), 173-184.

Brewer, J.D. (2004). Ethnography in Cassell, C. & Symon, G. (Eds.) *Essential Guide to Qualitative Methods in Organisational Research*. London: Sage Publications, pp.312-322.

Brewer, M. B. (2001). The many faces of social identity: implications for political psychology. *Political Psychology,* Vol. 22 (1), 115-125.

Brewer, M.B. and Gardner, W. (1996). Who is this 'We'? Levels of collective identity and self representations. *Journal of Personality and Social Psychology,* Vol. 71 (1), 83-93.

Broadfoot, K., Deetz, S. & Anderson, D. (2004). Multi-levelled, multi-method approaches in organisational discourse in Grant, D., Hardy, C., Oswick, C. & Putnam, L. (Eds.) (2004) *The Sage Handbook of Organisational Discourse*. London: Sage Publications, pp. 193-212.

Brown, A. D. (2001). Organisation studies and identity: towards a research agenda. *Human Relations,* 54 (1), 113-121.

Bryman, A. & Burgess, R. G. [Eds] (1994). *Analyzing Qualitative Data*. London: Routledge.

Bufton, S. (2005) Modern Matrons: can they be easily identified by hospital patients? *British Journal of Nursing,* Vol. 14 (22), 1186 -1190.

Bullivant, J.R.N. (1996). Benchmarking in the UK National Health Service. *International Journal of Health Care Quality Assurance,* Vol. 9 (2), 9-14.

Burrell, G. (2006). Foucauldian and Postmodern Thought in Korczynski, M., Hodson, R & Edwards, P. (Eds) *Social Theory at Work*. New York: Oxford University Press, pp. 155-181.

Burrell, G. and Morgan, G. (1979). *Sociological Paradigms and Organisational Analysis*. Heinemann Educational Books Ltd.

Burrell, G. (1988). Modernism, Post Modernism and Organisational Analysis 2: the contribution of Michel Foucault. *Organisation Studies*, Vol. 9 (2), 221-235.

Caldwell, R. (2007). Agency and Change: Re-evaluating Foucault's Legacy. *Organisation*, Vol. 14 (6), 769-791.

Callero, P. L. (2003). The Sociology of Self. *Annual Review of Sociology*, Vol. 29, 115-133.

Callero, P. L. (1991). Towards a Sociology of Cognition in *The self-society dynamic: cognition, emotion and action*. Howard, J.A & Callero, P (Eds). New York: Cambridge University Press, pp.43-54.

Camp, R.C. (1989). *Benchmarking. The search for industry best practices that lead to superior performance.* Milwaukee: American Society for Quality Control Quality Press.

Cassell, C. and Symon, G. (2004). *Essential Guide to Methods in Organisational Research.* London: Sage Publications.

Causer, G. & Exworthy, M. (1999). Professionals as managers across the public sector in Exworthy, M. & Halford, S. (Eds) *Professionals and the New Managerialism in the Public Sector*. Buckingham: Open University Press, pp.83-101.

Cerulo, K.A. (1997). Identity Construction, new issues, new directions. *Annual Review of Sociology,* Vol. 23, 385-409.

Collin, A. (1996). Organisations and the end of the individual? *Journal of Managerial Psychology*. Vol. 11 (7), 9-17.

Collins English Dictionary (2000) Fifth Edition. Glasgow: HarperCollins Publishers Ltd.

Cooper, R. & Burrell, G. (1988). Modernism, Post Modernism and Organisational Analysis: an introduction. *Organisation Studies,* Vol. 9 (1), 91-112.

Corbin, J. and Strauss, A. (2008). *The Basics of Qualitative Research* (Third edition). Thousand Oaks, CA: Sage Publications.

Côté, J. (2006). Identity Studies: how close are we to developing a social science of Identity? An appraisal of the field. *Identity*, Vol. 6 (1), 3-25.

Crawford, P., Brown, B. & Majomi, P. (2008). Professional identity in community mental health nursing: a thematic analysis. *International Journal of Nursing Studies,* Vol. 45 (7), 1055-1063.

Crotty, M. (2003). *The Foundations of Social Research: meaning and perspective in the research process*. London: Sage Publications.

Currie, G., Finn, R. & Martin, G. (2010). Role transition and the interaction of relational and social identity: new nursing roles in the English NHS. *Organisation Studies,* Vol. 31 (7), 941-961.

Currie, G., Koteyko, N. & Nerlich, B. (2009). The dynamics of professions and development of new roles in public services organisations: the case of the Modern Matrons in the English NHS. *Public Administration,* Vol. 87 (2), 295-311.

Currie, G. and Proctor, S. J. (2005). The Antecedents of Middle Managers' Strategic Contribution: The Case of a Professional Bureaucracy. *Journal of Management Studies,* Vol. 42 (7), 1325–1356.

Daily Mail Website. URL: http://www.dailymail.co.uk/health/article-175652/NHS-calls-Matrons-casualty.html [Date accessed: 10-Apr-2011].

Dann, G.S. (1979). Religion and Cultural Identity: the case of Umbanda. *Sociological Analysis,* Vol. 40 (3), 208-225.

Davies, C. (2002). Managing identities: workers, professions and identity. *Nursing Management,* Vol. 9 (5), 31-34.

Davies, H.T. & Lampel, J. (1998). Trust in performance indicators? *Quality in Health Care*, Vol. 7 (3), 159-162.

Day, M. (2005). Carry on, Matrons. The Telegraph Online. Published 20-Feb-2005. URL: http://www.telegraph.co.uk/news/uknews/1483944/Carry-on-matrons.html. [Date accessed: 25-May-2010].

Dealey, C., Moss, H., Marshall, J. & Elcoat, C. (2007). Auditing the impact of implementing the Modern Matron role in an acute teaching trust. *Journal of Nursing Management*, Vol. 15 (1), 22-33.

Deming, W. E. (1986) *Out of the Crisis*. Cambridge, Massachusetts: MIT Press.

Denscombe, M. (2007). The *Good Research Guide for small-scale social research projects* (Third Edition), Buckingham: Open University Press.

Dent, M. & Burtney, E. (1996). Managerialism and professionalism in general practice: teamwork and the art of pulling together. *Health Manpower Management*, Vol. 22 (5), 13-23.

Dent, M & Whitehead, S. (Eds.) (2002). *Managing Professional Identities: knowledge, performativity and the "new" professional*. London: Routledge.

Dent, M (2003). *Remodelling hospitals and health professionals in Europe*. Basingstoke: Palgrave Macmillan.

Dent, M., Chandler, J., & Barry, J. (Eds.) (2004) Introduction in *Questioning the New Public Management*. Aldershot: Ashgate Publishing Ltd, pp.1-6.

Dent, M & Barry, J. (2004). New Public Management and the Professional in the UK: reconfiguring control? in Dent, M., Chandler, J., & Barry, J. (Eds.) (2004) *Questioning the New Public Management*. Aldershot: Ashgate Publishing Ltd, pp.7-20.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (2000). *Handbook of Qualitative Research* (Second edition). London: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (2005). *Handbook of Qualitative Research* (Third edition). London: Sage Publications.

Department of Health (1998). *A First Class Service: quality in the new NHS*. London: Crown Copyright.

Department of Health (1999a). *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and health care*. London: Crown Copyright.

Department of Health (1999b). Clinical Governance in the New NHS. *Health Service Circular 1999/065*. Crown Copyright: London.

Department of Health (2000). The *NHS Plan: a plan for investment, a plan for reform*. London: Crown Copyright.

Department of Health (2001a). *The Essence of Care: patient focused benchmarking for health care practitioners*. London: Crown Copyright.

Department of Health (2001b). Implementing the NHS Plan: Modern Matrons: strengthening the role of ward sisters and introducing senior sisters. *Health Service Circular 2001/010*. London: Crown Copyright.

Department of Health (2003). *Modern Matrons: improving patient experience*. London: Crown Copyright.

Department of Health (2004). *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*. London: Crown Copyright.

Department of Health Website: The Essence of Care: Patient-focused benchmarking for health care practitioners. [Date accessed: 07-Jan-09] URL: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005475

Dew, K (2007). A health researcher's guide to qualitative methodologies. *Australian and New Zealand Journal of Public Health,* Vol. 31 (5), 433 – 437.

Dick, P. (2004). Discourse Analysis in Cassell, C. & Symon, G. (Eds.) (2004) *Essential Guide to Qualitative Methods in Organisational Research.* London: Sage Publications, pp.203-213.

Dopson, S. (2009). Changing forms of managerialism in the NHS: hierarchies, markets and networks in Gabe, J. and Calnan, M. (Eds) *New Sociology of the Health Service*. Oxon: Routledge, pp.37-55.

Eaves, Y. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing*. Vol. 35 (5), 654-663.

Edwards, R. (1979). *Contested Terrain: the transformation of the workplace in the twentieth century*. New York: Basic Books.

Elliot, J. (2003). Should modern matrons carry on? BBC News Online, Published: 14-04-2003. URL: http://news.bbc.cu.uk/go/pr/fr/-/1/hi/health/2936501.stm. [Date accessed: 04-May-2010].

Ellis, J.M. (2000). Sharing the evidence: clinical practice benchmarking to improve continuously the quality of care. *Journal of Advanced Nursing*, Vol. 32 (1), 215-225.

Ellis, J.M., Cooper, A., Davies, D., Hadfield, J., Oliver, P., Onions, J., Walmsley, E. (2000a). Making a difference to practice: clinical benchmarking. Part 1. *Nursing Standard*, Vol. 14 (32), 33-35.

Ellis, J.M., Cooper, A., Davies, D., Hadfield, J., Oliver, P., Onions, J., Walmsley, E. (2000b). Making a difference to practice: clinical benchmarking Part 2. *Nursing Standard*, Vol. 14 (33), 32-35.

Ellis, J.M. (2004). Evaluating the Effectiveness of Clinical Practice Benchmarking in Improving the Quality of Health Care. PhD Thesis. University of Central Lancashire.

Enderby, P., Hughes, A., John, A. & Petheram, B. (2003). Using benchmarking data for assessing performance in occupational therapy. *Clinical Governance*, Vol. 8 (4), 290-295.

Evetts, J. (2003a). The construction of professionalism in new and existing occupational contexts: promoting and facilitating occupational change. *International Journal of Sociology and Social Policy,* Vol. 23 (4/5), 22-35.

Evetts, J. (2003b). The sociological analysis of professionalism: occupational change in the modern world. *International Sociology,* Vol. 18 (2), 395-415.

Evetts, J. (2005). The management of professionalism: a contemporary paradox. Conference Paper: Changing Teacher Roles, Identities and Professionalism. King's College, London. 19th October 2005.

Ewens, A. (2003). Changes in nursing identities; supporting a successful transition. *Journal of Nursing Management*, Vol. 11 (4), 224-228.

Exworthy, M. & Halford, S. (1999). Assessment and Conclusions in Exworthy, M. & Halford, S. (Eds) *Professionals and the New Managerialism in the Public Sector*. Buckingham: Open University Press, pp.121-139.

Fagermoen, M.S. (1997). Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing,* Vol. 25 (3), 434-441.

Fairclough, N. (1992). *Discourse and Social Change.* Cambridge: Polity Press.

Fawcett, J. (2003). Guest Editorial: On bed baths and conceptual models of nursing. *Journal of Advanced Nursing*, Vol. 44 (3), 229-230.

Felluga, D. Modules on Butler: On Performativity. Introductory Guide to Critical Theory. Updated: Jan. 31, 2011. Purdue U. [Date accessed 12-04-11] http://www.purdue.edu/guidetotheory/genderandsex/modules/butlerperformativity.html

Ferlie, E., Pettigrew, I., Ashburner, L. & Fitzgerald, L. (1996). *The New Public Management in Action.* Oxford: Oxford University Press.

Fleming, G. (06-11-2009) Are student nurses too posh to wash? http://www.nursingtimes.net/whats-new-in-nursing/beyond-the-bedpan/beyond-the-bedpan/are-student-nurses-too-posh-to-wash/5008269.article. [Date accessed: 3-Mar-2011].

Flynn, N. (2007). *Public Sector Management*. Fifth Edition. London: Sage Publications.

Fondas, N. (1997). Feminization Unveiled: Management Qualities in Contemporary Writings. *The Academy of Management Review*, Vol. 22 (1), 257-282.

Forbes, T. & Hallier, J. (2006). Social Identity and self enactment strategies: adapting to change in professional-manager relationships in the NHS. *Journal of Nursing Management,* Vol.14 (1), 34-42.

Foucault, M. (1971). Orders of Discourse. *Social Science Information*, Vol. 10 (2), 7-30.

Foucault, M. (1982). The Subject and Power. *Critical Inquiry,* Vol. 8 (4), 777-795.

Fournier, V. (1999). The appeal to professionalism as a disciplinary mechanism. *The Sociological Review*, Vol. 47 (2), 280-307.

Freidson, E. (2001). *Professionalism: the third logic*. Cambridge: Polity Press.

General Medical Council Website. URL: http://www.gmc-uk.org/about/role.asp [Date accessed: 17-Mar-2011].

Gibbs, G. (2002). *Qualitative Data Analysis: explorations with NVivo*. Buckingham: Open University Press.

Giddens, A. (1991). *Modernity and Self Identity: self and society in the late modern age*. Cambridge: Polity Press.

Glaser, B.G. & Strauss, A. L. (1965). Discovery of Substantive Theory: a basic strategy underlying qualitative research. *American Behavioral Scientist,* Vol.8 (5), 5-12.

Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine Publishing Co.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* First Edition. New York: Anchor Books.

Goffman, E. (1990). *The Presentation of Self in Everyday Life*. New Edition. London: Penguin.

Gould, D. (2008). The Matron's role in acute National Health Service Trusts. *Journal of Nursing Management*, Vol. 16 (7), 804-812.

Grant, D., Hardy, C., Oswick, C. & Putnam, L. (eds.) (2004) *The Sage Handbook of Organisational Discourse.* London: Sage Publications.

Gray, B. (2009a). The Emotional Labour of Nursing 1: exploring the concept. *Nursing Times,* Vol. 105 (8), 26-29.

Gray, B. (2009b). The Emotional Labour of Nursing 2: analysing the barriers. *Nursing Times.* Vol. 105 (9), 24-26.

Halford, S. and Leonard, P. (1999). New identities? Professionalism, Managerialism and the construction of self in Exworthy, M. & Halford, S. (eds) *Professionals and the New Managerialism in the Public Sector.* Maidenhead: Open University Press, pp.102-120.

Hall, C. (11-05-2004). Young nurses 'too posh to wash.' http://www.telegraph.co.uk/news/uknews/1461504/Young-nurses-too-posh-to-wash.html [Date Accessed: 3-Mar-2011].

Hallam, J. (2000). *Nursing the Image: media, culture and professional identity*. London: Routledge.

Hallam, J. (2002). Vocation to profession: changing images of nursing in Britain. *Journal of Organisational Change Management,* Vol. 15 (1), 35-47.

Ham, C. (2003). Improving performance of health services: the role of clinical leadership. Viewpoint. *The Lancet* online: March 25, 2003 http://image.thelancet.com/extras/02art8342web.pdf [Date accessed: 31-03-2011].

Ham, C. (2009). *Health Policy in Britain*. Sixth Edition. Basingstoke: Palgrave Macmillan.

Hannigan, B. (1998). Assessing the new public management: the case of the National Health Service. *Journal of Nursing Management*, Vol. 6, (5), 307–312.

Harding, N. (2008). The "I", the "Me" and the "You Know": identifying identities in organisations. *Qualitative Research in Organisation and Management: An International Journal,* Vol. 3 (1), 42-58.

Harrison, S. (1999). Clinical autonomy and health policy: past and futures in M. Exworthy and S. Halford (Eds) *Professionals and the new managerialism in the public sector*. Buckingham: Open University Press, pp. 50–64.

Hartley, J. (2004). Case study research in Cassell, C. and Symon, G. (2004) *Essential Guide to Methods in Organisational Research*. London: Sage Publications, pp.323-333.

Hasselbladh, H. and Selander, M. (2003) Plural frames of work in public sector organisations Barry, J., Dent, M., & O'Neill, M. (Eds) *Gender and the Public Sector*. Oxon: Routledge, pp. 120 - 135.

Hatch, M.J & Cunliffe, A. (2006). *Organisation Theory.* 2nd Edition, Oxford: Oxford University Press.

Hewison, A. (1999). The New Public Management and the New Nursing: related by rhetoric? Some reflections on the policy process and nursing. *Journal of Advanced Nursing*, Vol. 29 (6), 1377 – 1384.

Hodder, I. (2000). The Interpretation of Documents and Material Culture in Denzin, N. K., & Lincoln, Y. S. (Eds.) (2000). *Handbook of Qualitative Research (Second Edition).* London: Sage Publications, pp. 703-715.

Hodkinson P. & Hodkinson, H. (2001). The Strengths and Limitations of Case Study Research. Conference Paper presented to the Learning and Skills Development Agency conference: Making an Impact on Policy and Practice, Cambridge, 5-7 December 2001.

Holstein, J.A. & Gubrium, J.F. (2000). *The Self We Live By: narrative identity in a postmodern world.* New York: Oxford University Press.

Hood, C. (1991). A public management for all seasons? *Public Administration,* Vol. 69 (Spring), 3-19

Hood, C. (2007). Public Service Management by Numbers: Why Does it Vary? Where Has it Come From? What Are the Gaps and the Puzzles? *Public Money & Management,* Vol. 27 (2), 95-102.

Horton, S. (2006). New Public Management: its impact on public servant's identity: an introduction to this symposium. *International Journal of Public Sector Management,* Vol. 19 (6), 533-542.

Hotho, S. (2008). Professional identity – product of structure, product of choice: linking changing professional identity and changing professions. *Journal of Organisational Change Management,* Vol. 21 (6), 721-742.

Houston, S. (2001). Beyond social constructionism: critical realism and social work. *British Journal of Social Work*, Vol. 31 (6), 845-861.

Howard, J.A. (1991). Introduction: the self-society dynamic in Howard, J.A & Callero, P.L. (Eds) *The Self-Society Dynamic: Cognition, Emotion and Action*. New York: Cambridge University Press, pp.1-17.

Hughes, E. (1963), The Professions. *Daedalus*, Vol. 92 (4), 655-668.

Jackson, N. and Carter, P. (2000). *Rethinking organisational behaviour*. Harlow: Financial Times, Prentice Hall.

Kelly, B. (1991). The professional values of English nursing undergraduates. *Journal of Advanced Nursing,* Vol. 16 (7), 867-872.

Kemmis, S. & McTaggart, R. (2000). Participatory Action Research in Denzin, N. K., & Lincoln, Y. S. (Eds.) (2000). *Handbook of Qualitative Research (Second Edition).* London: Sage Publications, pp. 567-606.

Keogh, J. (1997). The professionalisation of nursing: development, difficulties and solutions. *Journal of Advanced Nursing,* Vol. 25 (2), 302-308.

King, N. & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage Publications.

King, N. (2004). Using templates in the thematic analysis of text in Cassell, C and Symon, G. (2004) *Essential Guide to Qualitative Methods in Organisational Research*. London: Sage Publications, pp.256-270.

Knight, P.T. (2002). *Small Scale Research: pragmatic inquiry in social science and the caring professions*. London: Sage Publications

Knights, D. and Wilmott, H. (1999). *Management Lives: power and identity in work organisations.* London: Sage Publications.

Koteyko, N. & Nerlich, B. (2008). Modern Matrons and infection control practices: aspirations and realities. *British Journal of Infection Control,* Vol. 9 (2), 18-22.

Kotter, J. (1995). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review,* Vol. 73 (2), 59-67.

Lane, K. (2006). The plasticity of boundaries: a case study of collaborative care in maternity services. *Health Sociology Review,* Vol. 15 (4), 341-352.

Langley, G.J., Nolan, K.M., Nolan, T.W., Norman, C.L. and Provost, L.P. (1996). *The Improvement Guide – A Practical Approach to Enhancing Organisational Performance*. San Francisco, CA: Jossey Bass.

Länsisalmi, H., Peiro, J-M. & Kivimaki, M. (2004). Grounded Theory in organisational research in Cassell, C and Symon, G. (2004) *Essential Guide to Qualitative Methods in Organisational Research.* London: Sage Publications, pp. 242-255.

Leidner, R. (2006). Identity and Work in Korczynski, M., Hodson, R & Edwards, P. (Eds) *Social Theory at Work*. New York: Oxford University Press, pp. 424-463.

Liaschenko, J. & Peter, E. (2004) Nursing ethics and conceptualisations of nursing: profession, practice and work. *Journal of Advanced Nursing,* Vol. 46 (5), 488-495.

Lofland, J., Snow, D., Anderson, L. & Lofland, L.H. (2006). *Analyzing Social Settings: a guide to qualitative observation and analysis* (Fourth Edition), Belmont, CA: Wadsworth.

Lozeau, D., Langley, A. & Denis, J.L. (2002) The corruption of managerial techniques by organisations. *Human Relations*, Vol. 55 (5), 537 – 564.

Macdonald, K. (2006). Professional Work in Korczynski, M., Hodson, R & Edwards, P. (Eds) *Social Theory at Work.* New York: Oxford University Press, pp.356-387.

Mackey, H. (2007). "Do not ask me to remain the same": Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal,* Vol. 54 (2), 95-102.

Macleod-Clark, J., Maben, J. & Jones, K. (1997). Project 2000: perceptions of the philosophy and practice of nursing: shifting perceptions - a new practitioner? *Journal of Advanced Nursing,* Vol. 26 (1), 161-168.

Malterud, K. (2001). Qualitative research: standards, challenges and guidelines. *The Lancet*. Vol. 358 (August 11), 483-488.

Matland, R. E. (1995). Synthesizing the Implementation Literature: the ambiguity-conflict model of policy implementation. *Journal of Public Administration Research and Theory*, Vol. 5 (2), 145-174.

Matykiewicz, L. & Ashton, D. (2005). Essence of Care benchmarking: putting it into practice. *Benchmarking: An International Journal,* Vol. 12 (5), 467 – 481.

Matykiewicz, L. & Baxter, L.F. (2010). Exploring policy implementation through gendered identity and discourse: Modern Matrons, Essence of Care and NHS Reform. Paper presented at the Gender, Work and Organisation Conference, June 2010, Keele University.

Mays, N. & Pope, C. (1995). Qualitative Research: Rigour and qualitative research. *British Medical Journal*, Vol. 311 (July), 109-112.

Mazmanian, D & Sabatier, P. (1989) *Implementation and public policy*. University Press of America.

McNeese-Smith, D.K. & Crook, M. (2003). Nursing values and a changing nursing workforce. *Journal of Nursing Administration,* Vol. 33 (5), 260-270.

McMurray, R. (2007). Our reforms, our partnerships, same problems: the chronic case of the English NHS. *Public Money and Management,* Vol. 27 (1), 77-82.

McMurray, R. (2010). The struggle to professionalize: an ethnographic account of the occupational position of Advanced Nurse Practitioners. *Human Relations*. XX (X), 1-22.

Mead, G. H. (1934) *Mind, self and society from the standpoint of a social behaviourist.* Chicago: Chicago University Press.

Meulenbergs, T., Verpeet, E., Schotsmans, P. & Gastmans, C. (2004). Professional codes in a changing nursing context: literature review. *Journal of Advanced Nursing*. Vol. 46 (3), 331-336.

Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: an expanded sourcebook*. 2nd Edition. London: Sage Publications.

Millward, L.J. & Bryant, K. (2005). Clinical Leadership in Health care: a position statement. *Leadership in Health Services*, Vol. 18 (2), xiii – xxv.

Mintzberg, H. (1979). Structure in 5s: a synthesis of the research on organisation design. *Management Science*, Vol. 26 (3), 322-341.

Mooney, H. (2008). Are Modern Matrons making a difference? Nursing Times.net. Online article: http://www.nursingtimes.net/nursing-practice-clinical-research/are-modern-Matrons. [Date accessed: 04-05-10].

Morgan, G. (1997). *Images of Organisation*, 2nd Edition. London: Sage Publications.

Moss, L., (11-05-2004) Nurses 'too posh to wash' miss vital symptoms. http://www.independent.co.uk/life-style/health-and-families/health-news/nurses-too-posh-to-wash-miss-vital-symptoms-562976.html [Date accessed: 3-Mar-2011].

NHS Website (a) http://www.nhscareers.nhs.uk/details/Default.aspx?Id=796 [Date accessed: 6-Apr-2011].

NHS Website (b) http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx [Date accessed: 13-Mar-2011].

O'Connor, K.E. (2008). "You choose to care": teachers, emotions and professional identity. *Teaching and Teacher Education,* Vol. 24 (1), 117-126.

Öhlén, J.& Segesten, K. (1998). The professional identity of the nurse: concept analysis and development. *Journal of Advanced Nursing,* Vol. 28 (4), 720-727.

Paulson, N. (2006). New public management, innovation and the non-profit domain: new forms of organising and professional identity in Veenswijk, M. (Ed.) *Organising Innovation: New Approaches to Cultural Change and Intervention in Public Sector Organisations*. Amsterdam: IOS Press, pp. 15-28.

Payne, G & Payne, J. (2004) *Key concepts in social research.* London: Sage Publications.

Pettigrew, A., Ferlie, E. & McKee, L. (1992). *Shaping Strategic Change*, London: Sage Publications.

Piekkari, R., Welch, C. & Paavilainen, E. (2009). The Case Study as Disciplinary Convention : Evidence From International Business Journals. *Organisational Research Methods,* Vol. 12 (3), 567-589.

Pollitt, C. (2003) *The Essential Public Manager.* Maidenhead: Open University Press.

Pope, C., Robert, G., Bate, P., Le May, A & Gabbay, J. (2006). Lost in translation: a multi-level case study of the metamorphosis of meanings and action in public sector organisational innovation. *Public Administration* Vol. 84 (1), 59–79.

Pope, C., van Royen, P. & Baker, R. (2002). Qualitative Methods in research on health care quality. *Quality and Safety in Health Care,* Vol. 11 (2), 148-152.

Pullen, A. (2006). *Managing Identity*. Basingstoke, Hampshire: Palgrave Macmillan.

Pullen, A. and Simpson, R. (2009). Managing difference in feminised work: Men, otherness and social practice. *Human Relations.* Vol. 62 (4), 561-587.

Quinn, J. B., Anderson, P., and Finkelstein, S., (1996). 'Leveraging intellect' *Academy of Management Executive,* Vol 10 (3), 7-27.

Rattansi, A. and Phoenix, A. (2005). Rethinking youth identities: modernist and post modernist frameworks. *Identity,* Vol. 5 (2), 97-123.

Read, S., Ashman, M., Scott, C. & Savage, J. (2004). Evaluation of the Modern Matron role in a sample of NHS Trusts. RCN Institute/School of Nursing and Midwifery, University of Sheffield, Sheffield.

Richards, L. (2009) *Handling qualitative data: a practical guide*. London: Sage Publications.

Rosseau, D.M. & Fried, Y. (2001). Location, Location, Location: contextualising organisational research. *Journal of Organisational Behaviour,* Vol. 22 (1), 1-13.

Rowlinson, M. (2004). Historical Analysis of Company Documents in Cassell, C and Symon, G. (2004) *Essential Guide to Qualitative Methods in Organisational Research.* London: Sage Publications, pp.301-311.

Ryan, M. K., & Haslam, S. A. (2005). The Glass Cliff: Evidence that Women are Over-represented in Precarious Leadership Positions. *British Journal of Management*, Vol. 16 (2), 81-90.

Salvage, J. (1988). Professionalisation—or struggle for survival? A consideration of current proposals for the reform of nursing in the United Kingdom. *Journal of Advanced Nursing.* Vol. 13 (4), 515-519.

Salvage, J. (2006). More than a makeover is needed to improve nursing's image. 30th Anniversary Invited Editorial. *Journal of Advanced Nursing,* Vol. 54 (3), 259-260.

Samra-Fredericks, D. (2004). Talk-in-interaction/conversation analysis in Cassell, C and Symon, G (2004) *Essential Guide to Methods in Organisational Research*. London: Sage Publications, pp.214-227.

Sanders, C. (2002) LEO makes managers kings of jungle. http://www.timeshighereducation.co.uk/story.asp?storyCode=171830§ioncode=26 [Date accessed: 24-03-2011].

Saunders, M., Lewis, P. & Thornhill, A. (2000) *Research Methods for Business Students (Second Edition).* Harlow: Financial Times Prentice Hall.

Savage, J. and Scott C. (2004). The Modern Matron: a hybrid management role with implications for continuous quality improvement. *Journal of Nursing Management,* Vol. 12 (6), 419-426.

Scott, H. (2004). Are nurses 'too clever' and 'too posh to wash'? *British Journal of Nursing,* Vol. 13 (10), p.581.

Sehested, K. (2002). How new public management reforms challenge the roles of professionals. *International Journal of Public Administration*, Vol. 25 (12), 1513-1537.

Sluss, D.M and Ashforth, B.E (2007). Relational Identity and identification: defining ourselves through work relationships. *Academy of Management Review*. Vol. 32 (1), 9-32.

Smircich, L. & Morgan, G. (1982). Leadership: the management of meaning. The Journal of Applied Behavioural Science. Vol. 18 (3), 257-273.

Smith, A. (2008a). Modern Matrons: reviewing the role. *Nursing Management,* Vol.15 (4), 20-25.

Smith, A. (2008b). Modern Matrons: reviewing the role. *Nursing Management,* Vol.15 (5), 18-26.

Smith, C. (2000) Content Analysis and Narrative Analysis in Reiss, H.T. & Judd, C. M (Eds) *Handbook of Research Methods in Social and Personality Psychology*. Cambridge: Cambridge University Press, pp.313-335.

Smith, P. (2005). Performance measurement in health care: history, challenges and prospects. *Public Money and Management*, Vol. 25 (4), 213-220.

Snell, J. (2001). Thoroughly modern matron. Health Service Journal Online. Published: 1 March, 2001. URL: http://www.hsj.co.uk/thoroughly-modern-matron/23704.article. [Date accessed: 04-May-2010].

Sommerlad, H. (2007). Researching and theorising the processes of professional identity formation. *Journal of Law and Society*. Vol. 34 (2), 190-217.

Stake, R. E. (2000). Case Studies in Denzin, N. K., & Lincoln, Y. S. (Eds.) (2000). *The Handbook of Qualitative Research (Second Edition)* London: Sage Publications, pp. 435-454.

Stephens, L. (2002). Modern Matron or traditional battleaxe? *British Journal of Midwifery,* Vol. 10 (5), 322.

Stets, J & Burke P (2000). Identity Theory and Social Identity Theory. *Social Psychology Quarterly*, Vol. 63 (3), 224-237.

Stewart, C. (1999). Syncretism and its synonyms: reflections on cultural mixture. *Diacritics,* Vol. 29 (3), 40-62.

Stewart, C. & Shaw, R. [Eds] (1994). *Syncretism/Anti-Syncretism: the politics of religions synthesis.* London: Routledge.

Stoner, B.P. (1986). Understanding Medical Systems: traditional, modern and syncretic health care alternatives in medically pluralistic societies. *Medical Anthropology Quarterly*. Vol. 17 (2), 44-48.

Stryker, S. (1991) Exploring the relevance of social cognition for the relationship of self and society: linking the cognitive perspective and identity theory in Howard, J.A & Callero, P.L (Eds) The *Self-Society Dynamic: Cognition, Emotion and Action.* New York: Cambridge University Press, pp. 19-42.

Stryker, S. and Burke, P. (2000). The Past, Present and Future of an Identity Theory. *Social Psychology Quarterly*, Vol 63 (4) 284-297.

Sveningsson, S. and Alvesson, M. (2003). Managing managerial identities: organisational fragmentation, discourse and identity struggle. *Human Relations,* Vol. 56 (10), 1163-1193.

Takase, M., Maude, P. & Manias, E. (2006). Impact of the perceived image of nursing on nurses' work behaviour. *Journal of Advanced Nursing,* Vol. 53 (3), 333-343.

Taylor, D. (1998). Social Identity and Social Policy: engagements with postmodern theory. *Journal of Social Policy*, Vol. 27 (3), 329-350.

Taylor, G. & Hawley, H. (2010) *Key Debates in Health Care*. Berkshire: Open University Press/McGraw Hill.

Taylor, J. (1997). Nursing ideology: identification and legitimacy. *Journal of Advanced Nursing*, Vol. 25 (3), 442-446.

Tedlock, B. (2000). Ethnography and Ethnographic Representation in Denzin, N. K., & Lincoln, Y. S. (Eds.) (2000) *Handbook of Qualitative Research (Second Edition).* London: Sage Publications. pp. 455-486.

Trust Annual Report [online], Trust Website [accessed 02-Apr-2011].

Trust Website [online] Matron in Lilac [accessed 13-Mar-2011].

Waddington, D. (2004) Participant Observation in Cassell, C. and Symon, G. (2004) *Essential Guide to Methods in Organisational Research*. London: Sage, pp.154-164.

Walshe, K. (2010). Reorganisation of the NHS in England. *British Medical Journal*. Vol. 341 (24 July): C3843, p.160.

Washer, P. & Joffe, H. (2006). The Hospital "Superbug": Social Representations of MRSA. *Social Science and Medicine,* Vol. 63 (8), 2141-2152.

Watson, G.H. (1993). *Strategic benchmarking. How to rate your company's performance against the world's best.* New York: Wiley.

Weick, K.E. (1995). *Sensemaking in Organisations*. Thousand Oaks, CA: Sage Publications.

Werbner, R. (1994). Afterword in Stewart, C. & Shaw, R. [Eds] (1994) Syncretism*/Anti-Syncretism: the politics of religions synthesis*. London: Routledge, pp.201-204

Whitchurch, C. (2008). Beyond administration and management: reconstructing the identities of professional staff in UK higher education. *Journal of Higher Education Policy and Management,* Vol. 30 (4), 375-386.

White, K. (2002). Nursing as Vocation. *Nursing Ethics*, Vol. 9 (3), 279-290.

Whitehead, S. (2003) Identifying the professional 'man'ager: masculinity, professionalism and the search for legitimacy in Barry, J., Dent, M., & O'Neill, M. (Eds) *Gender and the Public Sector*. Oxon: Routledge, pp. 85-103.

Wicks, R. (2008) Friedrich Nietzsche. Stanford Encyclopaedia of Philosophy. URL http://plato.stanford.edu/entries/nietzsche/ [Date accessed: 29 July 2009].

Wilmott, H. (1993). Breaking the paradigm mentality. *Organisation Studies*, Vol. 14 (5), 681-719.

Wilson, H. & Hutchinson, S. (1996). Methodologic mistakes in Grounded Theory. *Nursing Research*, Vol. 45 (2), 122-124.

Ybema, S., Keenoy, T., Oswick, C., Beverungen, A., Ellis, N. & Sabelis, I. (2009). Articulating Identities. *Human Relations*, Vol. 62 (3), 299-322.

Yin, R. K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.

Zairi, M. (1992) *Competitive Benchmarking: an executive guide*. Bradford: Technical Communications Publishing Ltd.

Zhao, G. (2005). Playing as adaptation? Layered selfhood and self-regard in cultural contexts. *Culture & Psychology,* Vol. 11 (1), 5-27.

BIBLIOGRAPHY

Antrobus, S. (1999). Nursing leadership: influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing* Vol. 29 (3), 746-753.

Argyris, C (1976). Leadership and learning and changing the status quo. *Organisational Dynamics*. Vol. 4 (30), 29-43

Barbour, M. & Dodd, F. (2007). Comparing roles: senior nurses and Modern Matrons. *Nursing Management*, Vol. 14 (2), 30-34.

Baxter, L. F. & Hirschhauser, C. (2004). Reification and representation in the implementation of quality improvement programmes. *International Journal of Operations and Production Management,* Vol. 24 (2), 207-224.

Berg, A.M. (2006) Transforming public services – transforming the public servant? *International Journal of Public Sector Management*, Vol. 19 (6), 556-568.

Butler, J. (1999). Gender Trouble: feminism and subversion of Identity. New York: Routledge.

Carmel, E (1999). Concepts, context and discourse in comparative case study. *Social Research Methodology*. Vol. 2 (2), 141-150.

Chambers, N. and Jolly, A. (2002), "Essence of Care: making a difference" *Nursing Standard,* Vol. 17 (11), 40-4.

Cowie, H., Smith, P. & Lorentzon, M. (2008). Leadership for learning: a literature study of leadership for learning in clinical practice. Surrey Scholarship Online. University of Surrey. http://epubs.surrey.ac.uk/divHealthSocialCare/1 [Date accessed: 06-05-2010]

Davies, C. (1996) The sociology of professions and the profession of gender. *Sociology*, Vol. 30 (4), 661-678.

Davies, H.T.O. and Nutley, S.M. (2000), "Developing learning organisations in the new NHS" *British Medical Journal*, Vol. 320, 998-1001.

de Burca, S. (2000), "The learning health care organisation" *International Journal for Quality in Health Care,* Vol. 12 (6), 457-8.

Geoghegan, J. (2006). Performance Managing Matrons. *Nursing Management,* Vol.13 (5) 26-29.

Greener, I. (2009). *Public Management: a critical text*. Basingstoke: Palgrave Macmillan.

Handsfield, L.J., Crumpler, T.P. and Dean, T.R. (2010). Tactical Negotiations and Creative Adaptations: The Discursive Production of Literacy Curriculum and Teacher Identities Across Space-Times. *Reading Research Quarterly,* Vol. 45 (4), 405-431.

Hantrais, L. (1999). Contextualisation in cross-national comparative research. *Social Research Methodolog,*. Vol. 2 (2), 93-108.

Hochschild, A.R. (1979) Emotion Work, Feeling Rules and Social Structure. *The American Journal of Sociology,* Vol. 85 (3), 551-575.

Hochschild, A. R. (2003) *Commercialization of intimate life: notes from home and work*. Berkeley: University of California Press.

Hollway, W. (2006). *The Capacity to Care, Gender and Ethical Subjectivity*. London: Routledge.

Lewis, A. L. (2010). School leaders as both colonized and colonizers: understanding Professional identity in an era of no child left behind. PhD Thesis. Graduate College of the University of Illinois at Urbana-Champaign.

Mannion, R., Davies, H., Marshall, M. (2005). Impact of star performance ratings in English Acute Hospital Trusts. *Journal of Health Service Research Policy,* Vol. 10 (1), 18-24.

Morgan, J. and Everett, T. (1990). "Introducing quality management in the NHS", *International Journal of Health Care Quality Assurance*, Vol. 3 (5), 23-35.

Phillips, N and Hardy, C. (2002) Discourse Analysis: investigating processes of social construction. Sage University Papers Series on Qualitative Research Methods, Vol. 50. Thousand Oaks, CA: Sage Publications.

Shortell, S. M. (1999). The Emergence of Qualitative Methods in Health Services Research. *Health Services Research*, Vol. 34 (5), 1083-1090.

Tschudin, V. (1999) *Nurses Matter: reclaiming our professional identity*. Basingstoke: Palgrave Macmillan.

Warwick, P. (2007) Back to the future in NHS Reform. *Journal of Health Organisation and Management*, Vol. 21 (2), 194-204.